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AFTER A WHILE NO ONE BELIEVES YOU

- Menges, L. J.  
1981 Chronic pain patients: Some psychological aspects. In *Persistent pain: Modern methods of treatment*, vol. 3, S. Lipton and J. Miles, eds., 87-98. New York: Academic Press.
- 7 1984 Pain: Still an intriguing puzzle. *Social Science and Medicine*, vol. 19, no.12: 1257-1260.
- Merskey, H.  
1978 Pain and personality. In *The psychology of pain*, R. A. Sternbach, ed., 111-127. New York: Raven Press.
- Palazzoli, M. S., et al.  
1978 *Paradox and counter paradox*. New York: Jason Aronson.
- Parsons, T.  
1951 *The social system*, chap. 10. New York: Free Press.
- Pilowski, I.  
1978 Psychodynamic aspects of the pain experience. In *The psychology of pain*, R. A. Sternbach, ed., 203-217. New York: Raven Press.
- Pinsky, J. J.  
1975 Psychodynamics and psychotherapy in the treatment of patients with chronic intractable pain. In *Pain: Research and treatment*, B. L. Crue, ed., 383-399. New York: Academic Press.
- Randle, W.  
1975 The role of the social worker as a change agent in the pain center. In *Pain: Research and treatment*, B. L. Crue, ed., 347-352. New York: Academic Press.
- Sarno, J. E.  
1976 Chronic back pain and psychic conflict. *Scandinavian Journal of Rehabilitation Medicine* 8:143-153.
- Schaeffer, P.  
1983 Learning to be a chronic pain patient. *Aches and Pains*, vol. 4, no. 4 (April): 21-25.
- 3 Siegel, B.  
1986 *Love, medicine and miracles*. New York: Harper & Row.
- Sternbach, R.  
1978 Clinical aspects of pain. In *The psychology of pain*, R. A. Sternbach, ed., 241-264. New York: Raven Press.
- Stone, D.  
1979 Diagnosis and the dole: The function of illness in American distributive politics. *Journal of Health Politics, Policy and Law*, vol. 4, no. 3:507-521.
- Tipton, S. M.  
1982 *Getting saved from the sixties*. Berkeley, Los Angeles, London: University of California Press.
- Wingertter, T.  
1975 Occupational therapy for the patient with intractable pain. In *Pain: Research and treatment*, B. L. Crue, ed., 359-363. New York: Academic Press.
- 8 Young, A.  
1980 An anthropological perspective on medical knowledge. *Journal of Medicine and Philosophy*, vol. 5, no. 2:102-116.

## CHAPTER SEVEN

# Pain and Resistance: The Delegitimation and Relegitimation of Local Worlds

Arthur Kleinman

Chronic pain's uncertain etiology and even more uncertain treatment, its inseparability from the local worlds of sufferers' lived experience, its changing forms and significance in different social contexts, perhaps above all its intractable opposition to interpretation—all make it a particularly rich subject for anthropology. Chronic pain challenges the simplifying Cartesian dichotomies that still are so influential in biomedicine and also in North American culture: for example, the complaints of chronic pain patients regularly defeat easy definition as based upon "objective" or "subjective" evidence. The condition perplexes most those family members, clinicians, and researchers who have not liberated their thinking from "real" (i.e., physical) versus "functional" (i.e., psychological, therefore imaginary) categories.

Bioethicists, who are so preoccupied with the ethnocentric principle of personal autonomy as to regard it as the only solid ground of ethical choices in the hospital, do not know what to make of chronic pain. They do not want to hold cancer patients accountable for their pain; yet the bodies of most other chronic pain patients either reveal no biomedically ascertainable pathology or only such modest pathology that it seems grossly incommensurate with complaints or the cost of care. Are these millions of sufferers responsible for their conditions? Should their care be rationed because it is not "really" necessary? Are they malingers? Because most workers disabled by chronic pain earn considerably less from disability support than from their job, because many have taken years to grudgingly receive even the limited, stigmatized compensation they do win, and because many are seriously depressed by their disabled condition, it is hard to see one's way to the standard claim of political conservatives that rewards for illness behavior directly encourage malingering (Osterweis et al. 1986). Psychodynamic, behavioral, and most social psychological conceptualizations, though they may at times

help in the care of a particular patient or even a special group of patients, also appear seriously inadequate when applied to the broad, multiform class of chronic pain patients.

Social science research on chronic pain syndromes has in the past emphasized the obvious economic costs of these conditions—costs to the health-care and disability systems and to industry and the economy generally. The professional discourse of economists and political scientists—the latter constructing the terms for political debate over disability compensation—dominate policy analyses of chronic pain (*ibid.*). Sociologists, who have studied the institutional settings where pain is treated, such as hospitals, clinics, and rehabilitation units, have drawn attention to the negative consequences of the medicalization of pain: professional misuse and abuse of dangerous and expensive tests and treatments, patient experiences of enforced dependency and alienation, and the transformation of human experience into a bureaucratized object and even standardized commodity: *the pain patient*, for whom countless drugs and all sorts of standard and off-beat interventions are marketed as *pain relievers* (Kotarba 1983; Strauss 1970). Studies have repeatedly documented that pain patients feel biomedical practitioners routinely delegitimize the experience of their illness, pressing them to believe that it is not real or, at least, not as serious as they fear it to be (Hilbert 1984). Their subjective reports of distress are challenged, and disconfirmed. They feel violated by practitioners, betrayed by biomedicine. And that encraving and deeply angering sensibility carries over into their family and work settings (Corbett 1986; Kleinman 1988a:56–99).

The questions for anthropologists, then, are perforce diverse. They overlap with the topics that other social scientists have seized upon, yet reflect abiding interests in medical anthropology: the political economy of disability; the social construction of illness categories; the cultural structuring of the course of illness as a form of experience; the biocultural interactions between family, work, and the psychophysiology of the person in pain; the micropolitical use of symptoms as idiom of distress and rhetoric for conducting interpersonal negotiations; the ethnography of therapeutic communities; the differing reactions to care across gender, ethnic, and class lines. The chapters in this volume attest to this diversity of interests, exemplifying how even members of the same anthropological research group construct the subject of anthropological enquiry into chronic pain in rather different ways. Pain's sheer inexhaustibility as a subject for conceptualization and empirical study is a statement about how deeply its roots tap the sources and express the forms of human conditions. Pain eludes the discipline's organized explanatory systems as much as it escapes the diagnostic net of biomedical categories.

Against this background, I choose to address two sides of chronic pain: (1) how, in the context of local moral worlds, different intersubjective experi-

ences of suffering get constructed, and particularly, in the case of pain in North America and China, how that construction turns on experiences of delegitimation and relegitimation; and (2) how one particular cultural interpretation—conceptualizing the experience of chronic pain as the embodiment of *resistance*—can represent the possibilities but also the limitations of anthropological interpretation of suffering.

I will draw on the illness experiences told to me by several of the patients in the Harvard study to illustrate these aspects of chronic pain. Elsewhere (Kleinman 1988a), I have written illness narratives of three of the patients I interviewed in order to understand the varieties of suffering as moral experience. Here I sketch the outlines of several exemplary narratives in order to demonstrate how pain emerges in local life worlds as *resistance* to the lived flow of interpersonal experience and in the micropolitics of social relations that have come under larger, menacing societal pressures. To further develop this line of analysis, I draw a comparison with chronic pain patients I interviewed in China (Kleinman 1986).

#### LOCAL MORAL WORLDS AND THE INTERSUBJECTIVITY OF EXPERIENCE

In his evocative, if enigmatic, thesis on *The Normal and the Pathological* (1989), Georges Canguilhem, the middle link in the intellectual chain of modern French philosophers of science from Gaston Bachelard to Michel Foucault, argued that the central task for a cultural analysis of science is to disclose how a particular scientific practice constructs the object of its enquiry. Canguilhem reasoned that for biomedicine, at best only a partial science, this construction must begin with the determination of the normal from the pathological. In his formulation, this determination had to reflect two conditions: the *norms* that the dominant social group establishes to evaluate and, therefore, control behavior, and also the vital condition of *abnormality* in the biological processes that participate in experience. Thus, for Canguilhem, the question of disease/illness is simultaneously a violation of the *normative* (the moral structure of society) as well as of the *normal* (the enfolding of that sociomoral structure into the body of the individual—its *embodiment*). The dialectical processes mediating the socially normative and the biologically normal are, for Canguilhem, the ontological *and* epistemological grounds for understanding health and disease.

I wish to rephrase this position to bring it into line with an emerging anthropological theory of human suffering, its sources and consequences (Kleinman and Kleinman 1991 in press). What distinguishes the anthropological theory from Canguilhem's approach, and also from that of phenomenologists such as Plessner (1970) and Merleau-Ponty (1962), who have addressed a similar question, and from Bourdieu (1977, 1989), who has ex-

explicitly called for a dialectical resolution to opposing subjectivist and objectivist accounts of social reality, is its emphasis on the central importance of the microcontexts of daily life. This anthropological approach to the study of human suffering also lays emphasis on the crucial work of ethnography to describe how microcontexts mediate the relationship between societal and personal processes.<sup>1</sup>

In the ethnographic perspective, those contexts of belief and behavior are *local moral worlds*, where, *inter alia*, the experience of illness is constructed (Kleinman 1980, 1986, 1988a). Local moral worlds—be they an East African village (a classical ethnographic context), an inner-city neighborhood in Istanbul, or a social network in North America's universe of plural life settings—are *particular, intersubjective, and constitutive* of the lived flow of experience. They are not simply reflections of macro-level socioeconomic and political forces, though they are strongly influenced by such forces. Within local moral worlds, the micro-level politics of social formations and social relationships, in the setting of limited resources and life chances, underwrite processes of contesting and negotiating actions. Yet local worlds are *not* for the most part so greatly fragmented or disorganized as to be lacking distinctive forms or coherence. What *unifies* divergent statuses and conflicting interests are the symbolic apparatuses of language, aesthetic preference, kinship and religious orientation, rhetoric of emotions, and common-sense reasoning, which, to be sure, derive from societal-level cultural traditions, yet are reworked to varying degrees in local contexts (Cassirer 1957). These symbolic forms work through individual and collective involvement in local social activities to construct the lived flow of experience. Hence, universal types of loss and menace—death, disease, disaffection—are made over into particular forms of bereavement, pain, and other experiences of suffering. For example, in a sensitive ethnography of the Kaluli of New Guinea, Steven Feld (1982) describes the construction of bereavement out of the memory associations of deceased persons with local places, the cosmology with its charter for teleology, the psychophysiological resonance of culturally marked sounds with similarly shaped sentiments.<sup>2</sup> The outcome is a local world of bereavement that is experientially greatly distinctive, yet is not so completely foreign as to lose all resemblance to what is shared in human conditions:

I place emphasis on the moral processes in these local worlds, because it is the construction of what is most at stake for persons and families which assembles from contested preferences and differing priorities a sociosomatic linkage between symbol systems and the body, between ethos and the person, which is responsible for the power of cultural meanings to provide structure for attention, memory, affect, their neurobiological correlates, and ultimately experience.<sup>3</sup> Experience, seen in this structured way, is only in part subjective. The developing child in her cultural context finds herself part of an ongoing flow of intersubjective feelings and meanings; in a sense, she

awakens cognitively and affectively within that flow. How to orient herself, what to orient to, her sense of what is most relevant result from the development of moral sensibility to the local world. Ethnic as well as personal identity emerge in this process of entering into and finding a structured place within the lived flow of experience. Social status, gender, and the micropolitical ecology will inflect those identifications, as will personal temperament. We will become ourselves as well as participants in the local world. And this plurality of influence is the basis of the novelty and indeterminacy of experience. But learning to live within and through the vital medium that emerges when symbolic forms interact with psychobiology places our lives squarely in the local flow of things, bound to others and to the moral meanings that define a local world.

And here, where persons encounter *pain*, is where we need to center the study of its sources and consequences. Thus, studying chronic pain patients means that each must be situated in a local world. That world must be described, and the description must include an account of the experience of pain in the wider context of experience in family, workplace, and community. To understand what chronic pain signifies, what its experience is like, ethnographers must work out a background understanding of local knowledge and daily practices concerning the body and the self, and of misfortune, suffering, and aspiration generally. And they must relate this background understanding to episodes of pain, courses of pain, and other aspects of the world of patients and families and practitioners who are responding to the exigency of pain. They must also interpret pain in the trajectory of a unique life course as it is told to them in a narrative of suffering that emerges from their positioned engagement with a person in pain. And therefore they must include in the analytic focus pain as a culturally constituted object for researchers. This agenda, though daunting, should sensitize the researcher to the generative matrix of processes in the local world through which chronic pain is constructed and by means of which, dialectically, chronic pain contributes to the further construction of experience.

#### RESISTANCE AND ITS MODES

I must narrow the focus of this analysis because of the requirements for a chapter-length treatment of a still-too-large subject. I discuss chronic pain only with regard to how the relationship between pain and moral world is illumined by two rather different aspects of *resistance*, a current interest of many anthropologists that I find both resonant and problematic. I employ the notion of resistance in the widely shared political sense of resistance to authority and in another somewhat special sense that emerges from my own theorizing about suffering.<sup>4</sup>

*Resistance as an Existential Process*

In the course of the lived flow of experience in local moral worlds, people come up against *resistance* to their life plans and practical actions (Scheler 1971:46). Resources are limited, often desperately so. The mobilization of force is inadequate, insufficient to achieve success in critical negotiations. And, most predictable of all, misfortune strikes. Loved ones die; others fall seriously ill or become incapacitated. Crops or businesses or marriages fail. Aspirations give way, gradually or, following a catastrophe, in a moment. Demoralization becomes desperate and poisons relationships. Loss, fear, menace derail life projects. For many, too many, vicious cycles of deprivation and oppression make misery the routine local condition. For those in the lowest socioeconomic strata, life is brutal. Persons are rendered wretched as a normal, day-to-day condition.

Bearing afflictions of the body, of the spirit, and of the social network and working through their distressing consequences are the shared existential lot of those whose life is lived at the edge of resistance in local worlds.<sup>5</sup> To this dark side of experience we give the name *suffering*, with all its moral and somatic resonances. Suffering, then, is the result of processes of resistance (routinized or catastrophic) to the lived flow of experience. Suffering itself is both an existential universal of human conditions *and* a form of practical and, therefore, novel experience that undergoes great cultural elaboration in distinctive local worlds (Kleinman 1988a, 1988b).<sup>6</sup>

*Resistance to Political Power*

In its more usual sense, resistance has the rather different meaning of resisting the imposition of dominating definitions (diagnoses), norms defining how we should behave (prescriptions), and official accounts (records) of what has happened.<sup>7</sup> We resist, in the micropolitical structure of local worlds, oppressive relationships. Such resistance may take the form of active struggle against dominant forces or a more passive form of noncompliance. The historical idea of resistance, such as that of the struggle of subordinate social groups with superordinate ones, conveys images of hidden motives, false compliance, malicious gossip, passive hostility, even sabotage (see Scott 1985:xvi, 290–291), which, I believe, though seemingly greatly distant from the domain of health, can be, with appropriate modifications, applied to less dramatic daily experiences of suffering, including that of chronic pain patients. Most patients with chronic illness, which by definition cannot be cured but must be endured, do not comply entirely with their doctor's prescription. There is little doubt that this "weapon of the weak" may be at times one of the few forms of resistance to medical authority that is feasible, even though it is often self-defeating.

Perhaps a more convincing example comes from bodily forms of expressing political alienation and resistance to the powers of authority. Starting in 1978, I began a series of studies of survivors of China's Cultural Revolution

who were suffering from chronic fatigue, weakness, pain, and dizziness (Kleinman 1986). These symptoms were usually diagnosed as neurasthenia, because no satisfactory biological pathology could be discovered. The neurasthenia patients whom I studied were frequently desperate, often depressed, and angry and alienated. Their illness narratives associated their symptoms with the brutal conditions of the Cultural Revolution. Telling their sickness story was a way of venting anguished grievance and hatred over what they perceived as the sociopolitical sources of their misfortune, which otherwise would have been a dangerously unsanctioned behavior. They also were engaged in negotiation with their work units' political leaders to improve work conditions, change jobs, retire, or return home from distant locations to which they had been involuntarily sent. The expression of their symptoms was a rhetoric of complaint aimed at negotiating improvements in life situations that they perceived as hampered or even ruined by political forces beyond their control. In these instances, bodily complaints could be seen as a means of resisting the diffused political control of the Communist state. Unfortunately, more frequently than not, these bodily expressions of disaffection and resistance, of what Scott (1990) so appropriately calls the "hidden transcript," were unavailing and even worsened personal and family problems. Nor were complaints of neurasthenia an effective means of constructing a collective discourse of wretchedness that was critical of the state and that could challenge its policies. Thus, illness as an idiom of distress and noncompliance with health care, in this Chinese instance at least, seemed to point up the limitations and even self-destructive potential of this form of resistance, a point to which I shall return below.

With this discussion as background, I turn to examine both types of resistance among patients with chronic pain in the local moral worlds canvassed in the Harvard chronic pain research projects.<sup>8</sup> My purpose is to see how useful this approach is in deepening our understanding of the experience of chronic pain as human suffering.

## THE DELEGITIMATION AND RELEGITIMATION OF EXPERIENCE

*Case 1*

Stella Hoff is a thirty-one-year-old Ph.D. biochemistry researcher in medicine who has suffered severe pain for four years following a car accident.

I could be dead or quadriplegic. As it was, I was totally, totally stunned. Shocked. I sat there and shook. At the hospital they diagnosed a concussion, and I had broken a few small bones in my foot. . . . Otherwise, there was nothing else injured. But right away I could feel pain. . . . And that started the whole process. Four years of pain, surgeries, casts, more pain, more tests, more drugs, more surgeries, bad surgical effects, and now this constant pain. . . . And me. us—our lives ruined. All for what?

Dr. Hoff is tall, angular, intense. A woman of few words, clipped accent, she is often biting sarcastic about others and herself. Dr. Hoff is elegantly but simply dressed; her movements represent her persona: quick, controlled, assured. In her white laboratory coat, surrounded by her research equipment and assistants, she looks the very epitome of precision and efficacy. A competent and conscientious scientist, she has also something distant, formal, even cold in her bearing. You need to meet her only once to appreciate a fixed expression of tension in her hyperalert eyes and thin, drawn mouth. The intensity of expression seems contentless: it could be fear, it could be hurt, it could be vulnerability. Once you know her story, there is little question what the intensity is about, however. It is her pain—constant, severe, dominating. Dr. Hoff is fighting each moment to remain in control, fighting not to give in, not to scream.

If I have gotten anything positive out of this terrible experience it is to be more sensitive to the experience of others, especially patients. I don't think doctors have any sense of how to deal with pain patients. . . . I was infuriated by an orthopedist who told me, "Well, it's just pain."

The words she uses to describe her pain are "exhausting, wretched, unbearable, agonizing." Nothing relieves this continuous pain. It is usually a five on a scale of ten in the morning, gets to seven of ten in the late afternoon when she leaves the laboratory, and in the evening is "at least" an eight. When the pain is greatly exacerbated, "it can be a twelve out of ten." The pain is much worse than any pain she experienced before, and is regularly "excruciating." For her pain symptoms and the related problems, Dr. Hoff sees a primary-care physician once every ten days on the average and specialist surgeons and pain experts. She has also consulted psychiatrists and several practitioners of alternative healing systems.

The pain and associated weakness affect most of her activities. It is extremely painful to work in the laboratory, though she does it. It is too painful to do yard work, clean the house, or cook anything involved or elaborate; she cannot play sports; and because of pain she avoids social activities. Pain keeps her in bed for most weekends each month. Over the eighteen months of follow-up interviews, Dr. Hoff's pain waxed and waned. On one occasion she had "very little pain" and reported "it is not interfering with my life very much." On another occasion the pain was "torturing and grueling," though it lasted at this intensity only a few days.

Dr. Hoff has insight into the personal meaning of her pain: "It has been totally devastating to me. Losses and what they have meant to me." She recognizes the pain has made her irritable, fearful, and overly attentive to bodily change.

On formal psychological testing, Dr. Hoff was found to be experiencing considerable anxiety, irritability, and fear. She felt blocked in getting things

accomplished, joyless, and she experienced rage, a desire to smash things, and a strong suspiciousness that others treated her badly, could not be trusted, and would take advantage of her if she did not exercise vigilance. Her psychiatric assessment was consistent with recurrent major depressive disorders for the past three years, for which she had received clinical trials of various antidepressants and psychotherapy, which had, in her words, "improved the depression but scarcely affected the pain."

Dr. Hoff's primary-care physician felt frustrated by her care. He estimated seeing her a hundred times or more over the previous four years. He regarded her as a "classical chronic pain syndrome" patient, and noted that her marital life, work, and problematic experiences with the medical system had placed her in a situation of chronic stress, depression, and "self-destructive" anger. He thought there was a strongly psychosomatic component to her pain. He thought of her as one of the most difficult patients he had treated in a very busy practice. He took that to be the reason that led doctors to "drop her." "Let's face it, Arthur," he said, "she is a problem patient. She's just extremely demanding, and she doesn't get better. I feel I need all my skills and then some to stay in the office with her when things are bad. Also being a biological researcher doesn't help."

Other physicians she consulted complained of the same problems. "You know," said one of the pain specialists,

she is an academic researcher. She knows the language, the medicines. She's read more of the papers on this thing than I have. And she has had so many negative experiences already that she's wary. And then again she has this way of coming across like an intellectual machine rather than a person. I mean she is cold, no emotions, watching you all the time. I find myself trying to avoid treatment interventions that might possibly lead to bad side effects. . . . I mean it just makes the whole thing so much more complicated. . . . difficult. When I see her name on my list of patients for that day I feel on edge myself.

Dr. Hoff, in contradistinction, sees herself as the almost silent bearer of a misery only she and her husband know. "I have worked when the pain is a ten," she states emphatically through lips drawn tightly together.

Pain is too much for physicians to deal with. Most of us can't tolerate listening to people in pain. We want patients who get better, or better yet if they don't they shouldn't complain. Pain patients like me are a sign of the failure of the medical care system, of something terribly wrong at the core.

Dr. Hoff's anger at her professional colleagues is the other side of her anger at the pain and at herself.

Look what I lost because of it, and where I am now. I get angry with myself, but I can't express it, never could. I get very quiet, others learn to leave me alone—thus, I don't address it. My anger is even too much for Everett [her

*seemingly  
desperate*

|| \*

husband] to address. I lose confidence that I can control this damn thing, go on with it, have confidence in the future . . . get better.

Dr. Hoff is a laboratory researcher, an academic who does full-time medical research, who says she likes her work and is good at it,

but I have missed so much time because of the pain and the surgery that I still have to prove myself. I've lost time. My generation of researchers has moved on: they direct their own labs, have their own research program, some have tenure. I'm starting all over again. I've lost three or four years. I have to prove that I can put in a full research day, complete projects, that I'm like everyone else.

She describes lab life as hectic, pressured.

Previously I brought all my work home with me. It was bad for my family life and my own peace of mind. I felt driven, and would continue to work late into the night. I felt something tormenting me, driving me on.

Because of the time she has missed, Dr. Hoff has not received the promotion she believes she deserves, and she feels she has also missed out on professional opportunities, getting her name on papers coming out of the lab, traveling to meetings, and that even her salary has lagged behind.

It's distressing to be viewed as a risk. I used to be seen as a rising star. . . . There is the constant stress of producing, no matter how I feel, to be productive, act successful, present myself as healthy. But I'm not healthy; yet I can't be honest about how I do feel. Have to pretend. Also, I don't know myself how far I can go. . . . I've never had a chance to find out. I've got to be successful in this job: there aren't better ones available. And I've got my grant and am turning out the papers, "cutting the meat" as we say around here. But it isn't a single objective—I need to do the whole thing, to be a steadily productive, day in, day out, investigator—no matter how much pain I feel.

Dr. Hoff is presently negotiating a more stable position:

They still don't have the confidence in me. I ought to be head of my laboratory—the current head is someone who started after I did. I taught her techniques. I'm a perfectionist in everything I do and always have been. That's why it's so hard for me to accept [the effects of the pain]. . . . Even in writing up the data it takes me longer. I've got to do it my own way. It's overwhelming to do the research, analyze the data, present it, keep publishing, stay up-to-date with the literature, do my part in the marriage, in keeping up the house, and still be myself. I once thought I could do it all . . . but now I know I can't.

Accomplished in academic studies, Stella Hoff expected success at a high level. "I had very romantic fantasies of being world famous." The harsh realization set in and was intensified after the accident.

I recognized for the first time that I wasn't necessarily going to be famous or successful. I had given up writing . . . and in biochemistry I had my doubts. I didn't think I had the toughness to be a great researcher: to do something original and significant. That's why I worked so hard, spent all those hours. I kind of doubted I could "naturally" develop as a researcher. I started out well, but I soon began to have trouble. It is one thing completing a single study and quite another to undertake an entire project. The summer before the accident I began to get very serious doubts. Things were not going well. I began to think of other jobs; something to fall back on. I had driven to job interviews . . . I was chagrined—almost in a trance of unreality. I didn't like the places I visited and couldn't conceive of myself as simply . . . as simply a practicing [technician]. . . . I know it sounds terribly snobby, but I had always thought of myself as a scientist . . . it was a blow to my ego to interview for that job.

Perhaps this illness has prevented or rather delayed a coming to terms with success. So far I have been potential, not actual, success. I think of not succeeding because of the illness . . . but thinking through this condition . . . I'm beginning to wonder whether . . . [it] is not a disguised form of avoiding failure. I don't think I really believe that, but this set of interviews has set off all sorts of associations I haven't made before. I know there are times when stress makes my symptoms worse—lots of times—but then again I can name several very stressful times in the last year or so when my pain did not seem to be affected at all. I know that psychosomatic relations means in some way my mind should be influencing my illness. Strange to say, my experience is almost the reverse. I don't seem to be able through will or feeling or desire to influence my body. In fact my body seems to determine how I feel.

Regarding her family, Dr. Hoff says with a mixture of sadness and bitterness:

Now, they [her family] get pretty angry at me. They simply don't understand what is going on. In fact, my mother can't bear to talk about my illness. She reminds me how much illness she had, and still had five children, worked, got on with her life. My sickness has really affected them.

In the course of many hours of interviews, Stella Hoff went on to tell me about another side of her illness experience, a side she said she had never spoken about with her practitioners.

Do you believe in evil? I mean, we don't use the term in biomedicine, but it does describe experience. Suffering is an evil. I mean suffering that has no meaning, that brings nothing good with it. There is a spiritual side of my pain. That is what I mean by evil. My spirit is hurt, wounded. There is no transcendence. I have found no creativity, no meaning in this . . . this entirely horrible experience. There is no God in it. . . . It shatters all I took for granted and believed in. I came from a religious family, French Protestants. I was taught to put faith in God. All I was taught . . . all my family and personal life . . . has been shattered, taken away. . . .

Dr. Stella Hoff's experience of chronic pain spills over the frame of any single analytic focus. The richly human echoes and protean complexities quite obviously can (and probably should) be analyzed from a number of different perspectives.<sup>9</sup> From the one advanced in this chapter, I note that the catastrophic onset of her misfortune delegitimizes a world of experience that she associates with confidence, control, and success. It is a classic suburban, North American upper-middle-class world of academic achievement and promising professional career. Ambition, competition, and competence are personal dispositions structured within a local moral terrain in which progress is regarded as only natural and the actual range of life choices in fact appears almost limitless. (Dr. Hoff came of age in the 1960s and '70s, before the invention of the new tradition of American decline.) In this post-World War II era of great American wealth and empire, the social reality of the "people of plenty" structures the habitus (embodied cognitive and affective structures) of expectation of great success which reaffirms and recreates a social world preoccupied with winning—all components of the American upper-middle-class cycle of self-improvement and self-promotion.

Yet, there is also the hidden fear of "falling from grace," which helps to focus attention on what is culturally most at stake: economic advancement and social mobility, a secularized soteriology (Newman 1989). Not to rise is a threat to social persona and social esteem; it is often experienced by members of the American middle class as a shameful moral weakness. Dr. Hoff, even before her catastrophic accident, had a gnawing uncertainty about whether she would in fact make it in the high-pressured, high-status stakes of science. She had looked into an alternative applied career as a technician, even though it was close to unacceptable to her disposition and the actual values of her local world.

The accident, the injuries, the awful pain, and even the iatrogenic and frustrating medical care turned that world of experience on its head. In this single sense only, hers is like the experience of the multigenerational, inner-city poor, whose intersubjective world is structured by vicious, brutalized cycles of misery, where dispositions of hopelessness and hatefulness recreate and normalize the on-the-ground social reality—though her far greater resources and memory of a very different background augur for a vastly different future. Nonetheless, Stella Hoff does descend into a world of suffering whose bodily and affective processes structure and are structured by painful social relationships in workplace and family setting. She exchanges a world of aspiration for a world of despair, but unlike the truly disadvantaged, she retains the possibility of reemerging. Stella Hoff loses one world to enter another. Her experience of delegitimation is intensified by the responses of practitioners, who contribute to the disconfirming sense that the symptoms are somehow too extreme, too troubling, too difficult to control. There is the suspicion of amplification or exaggeration owing to psychological problems

and "stress." This latent, and at times even voiced, accusation challenges the validity of her illness experience and threatens to add the stigma of mental illness or even malingering. To demonstrate the serious burden of her suffering, the desperate desolation, Stella Hoff, like most other chronic pain patients, feels pressed to dramatize her symptoms. Her pain is twelve out of ten. This patently melodramatic device in turn confirms the suspicions of practitioners. The outcome is a poisoned clinical atmosphere in which trust and support—so central to the healing process—are replaced by suspicion, accusation, and ultimately a pervasive, mutually frustrating resentment that makes empathetic care virtually impossible.

The reverberations of this downward spiral include notably Dr. Hoff's literal experience of a spiritual fall from grace.<sup>10</sup> Demoralization as an intersubjective process of suffering shared by patient, family, and practitioners eventually resonates in existential and teleological language. Here the technical rationality and scientific intellectual devices of biomedicine cannot contain the participatory reasoning of the patient who seeks to understand not how but why, not causal mechanism but ultimate meaning, not reason for treatment failure but chance for salvation (see Tambiah 1990:101-110). Thus, Dr. Hoff's story underlines the capacity of suffering as a transpersonal experience to cross the artificial divides between values and practice, religion and medicine which have become so dysfunctional in the American health-care system. Pain, then, almost becomes an icon of cultural delegitimation of our society's priorities and practices. Perhaps this is why the image chronic pain patients present is viewed as so menacing, why pain patients are cast so often as modern pariahs.

Can we fit the image of resistance into this analysis too? Resistance, in the sense of barrier or opposition to the local flow of lived experience, clearly applies to Stella Hoff's traumatic injury and its desperate consequences. Yet I would argue that the other meaning of resistance—active or passive counterresponse to micropolitical dynamics and the macro-level forces that either intensify or moderate their effect—also can be made to apply. The trajectory of Dr. Hoff's pain, a particularizing *social course* of illness experience that is inimical to the biomedical claim of a *natural course* that unfolds from the disease process itself, spirals around her research work and the pressures of her academic career. Once in place, complaints of pain are readily absorbed into a language of complaint about the enormous pressures and perceived injustices of academic life. Pain is experienced as bridging somatic and social space. To a certain, quite limited extent, embodied pain sanctions opposition to the way the research experience is constructed, which provides an incremental gain in time and autonomy. Yet obviously these "gains" are very little compared to the losses that Dr. Hoff experiences on account of her chronic pain. More impressively, her chronic pain offers Dr. Hoff an occasion to oppose medical practices that routinely disaffirm her experience of com-



plaints as genuine and serious. And taking up an oppositional stance to authority also obviously resonates with her Huguenot heritage and her personality style. She has become, in the eyes of her professional care givers, a "problem patient": a derogatory, even stigmatizing label, that in my experience not infrequently means the patient is making demands that the practitioner will not or cannot meet. In Stella Hoff's case, more than one hundred visits to a primary-care physician over four years may well be so extensive a resort to medical care that few would see her needs as reasonable. But the source of the problem, notwithstanding the claims of her practitioners to the contrary, may well be the system of care and the actual experience of the care they provide. Dr. Hoff is insistent that her pain, including the fullness of her experience, be taken seriously. Her demands confront the inadequacy of the biomedical, including the psychiatric and psychological, approach to chronic pain. The recipient of iatrogenic treatment, she fights back, mobilizing knowledge, and professional and financial resources that most pain patients do not have available. She turns even her spiritual crisis into an assault on the dehumanizing language of a treatment system that addresses neither ethical nor teleological questions. She resists the inappropriate extension of biomedicine's rational technical manipulations into the domain of deeply intimate human experience that calls for compassion and witnessing. And ultimately her suffering challenges simplistic American cultural orientations about youth, health, and freedom.

And yet, as much as the metaphor of resistance reveals of those sides of the chronic pain experience that are often hidden under other social science rhetorics, other aspects of suffering seem obscured or perhaps even distorted by this analytic schema. There is a definite limitation to the applicability of this perspective, and that limitation indicates a more general problem with the anthropology of suffering. Before I examine that problem, however, I will provide a very brief account of another exemplary experience of chronic pain from the Harvard study. After that I will adumbrate, again very briefly, chronic pain patients' experiences from the research I have conducted in China, for the purpose of drawing a cross-cultural comparison.

#### *Case 2*

Mary Catherine Mullen is a thirty-year-old married woman from a poor Irish American family in Boston's South End, a bastion of Irish working-class culture, who has suffered from severe "migraine" headaches for five years. Greatly overweight, with a strong family history of headaches and diabetes, Mrs. Mullen fears that her headaches are not getting better, in spite of various medical treatments, and that she will have to endure them for the rest of her life, as has her mother. Her headaches are associated with a depressed and angry mood for which she sees a counselor weekly, and which has transformed her, she holds, into someone quite different from the shy,

smiling, self-effacing person she was as a child and adolescent. Mrs. Mullen attributes the onset of her headaches to her husband's alcohol abuse and the subsequent verbal and physical violence he directed at her, which made him, in her words, "a real Jekyll and Hyde."

When the headaches began, Mrs. Mullen was contemplating divorcing her husband. She was desperate to protect herself, and her then five-year-old daughter, from her husband's violence. She also felt trapped by her lifelong diffidence and incapacity to express her needs. Her husband's inability to find or hold good employment meant that they "lived from one paycheck to the next." The feeling of financial insecurity infiltrated other aspects of their life. There were no medical benefits; they were forced to stay in a room in her mother's house, which was undesirable to all, and Mrs. Mullen had to continue to work in a low-level, dead-end job in a local department store which she detested. Finally, she had the terrible apprehension that her husband would end up physically abusing their daughter, just as she had been abused by her own mother.

Her response to this intolerable life situation was a cycle of dysphoria from desolate depression to explosive anger. When depressed, usually at a time her husband was drunk, she became deeply hopeless and virtually immobile—unable to speak out or even act preventively to protect herself or her daughter. When angry, usually when her husband was sober, she would "lose control": scream, throw things, and shout out a litany of wrongs that oppressed her. She even feared that she herself would eventually batter her daughter, thereby copying her own mother, for whom she had come to have an inexhaustible well of anger.

Mary Catherine Mullen was the illegitimate first child of Maggie O'Leary, described by Mary Catherine as an "irresponsible, rebellious" teenager who had run away from a large family of hard-drinking Irish immigrants, and a much older man, who passed through Maggie's life in several intense weeks and then disappeared utterly. Her mother, whom Mary Catherine claims vehemently was "incompetent to care for me," virtually abandoned Mary Catherine, placing her with her own mother, while she wandered in a near alcoholic delirium from man to man. Finally, when Mary Catherine was six, Maggie O'Leary reappeared suddenly without prior notice one evening and immediately demanded her child be returned to her. Despite Mary Catherine's pleas that she remain with her grandmother, whom she had come to regard as her mother, she was forcibly repossessed and immediately entered into her mother's unstable, peripatetic life. She remembers these years of childhood and early adolescence as lacking in all security. She felt unloved and dangerously threatened by her mother's physical abuse. From this time onward, Mary Catherine felt a deep hatred for her mother. At age fifteen she had a sexual affair with an older laborer, which resulted in an abortion, about which she continues to feel guilt. She



now believes that she undertook this relationship and dropped out of school in order to break away from her mother and at the same time "to get back at her for all she had done to me." Soon after the abortion, she began to date and quickly married her current husband.

It is an abiding source of shame for Mrs. Mullen that the young couple eventually had to "beg" her mother to permit them to move into her house because of lack of funds to live on their own. At the time she felt trapped in her marriage, her work, and in her mother's home. She watched impotently as her mother took advantage of the situation, treating her like a maid and not providing Mary Catherine and her family with privacy. In spite of her growing anger, she felt incapable of defending herself by talking back to her mother or husband. "If something is on my mind, I can't say it, fear hurting someone's feelings. Can't say no to people."

Over the course of months, Mrs. Mullen descended into despair. She thought of her life as hopeless, and increasingly she felt inadequate and worthless. At one point she thought seriously of suicide. Then the headaches began. So severe were they that she felt compelled to withdraw to her bedroom, where she locked the door, lay on her bed, and remained in the dark until sleep obliterated her pain. Because of her pain, and in spite of the serious financial repercussion and in the face of angry protests from her husband and her mother, Mrs. Mullen quit her job. Within weeks, she determined that the headaches were so severe that she could no longer do housework or cook for her family either. Her husband took over these activities grudgingly, but over time he became more solicitous and helpful. Despite the absence of health insurance, Mrs. Mullen insisted on visiting physicians, including pain experts, who diagnosed migraine, tried her on various treatments, none of which has controlled the pain, and prescribed bed rest and avoidance of "stressful" activities. She further insisted that her husband and mother assume financial responsibility for these medical visits.

As Mrs. Mullen's pain experience deepened, her mother, like her husband, became sympathetic and began to help with the housework. Her husband quit drinking and has not drunk in the subsequent years. Her mother showed her affection, Mary Catherine asserts, "for the first time in my life."

They treat me the way I have to be treated [because of the headaches]—considerate. If they are not, I'll kill somebody! . . . Everyone stays out of my way when I have a headache and that's what I want them to do.

Although the headaches have continued over the five years, they have slowly begun to diminish in intensity and to become more "tolerable," though at times, particularly when Mrs. Mullen is "under stress," they return to the former level of severity. The depression has lightened, but the sense remains of a deep pool of hate that erupts into angry outbursts. At these times, Mrs. Mullen will "throw up" to her mother accusations about

the past. This is the first time in her life, she says, when she has been able to say the things she always had need to say to her mother but couldn't: namely, how she grew up terrified, feeling unloved and greatly vulnerable. When, at the times she is not in pain, she tries to discuss these problems, her mother still turns away from her, "she can't handle it." But during Mrs. Mullen's explosions of rage, her mother is forced to listen.

— The analytic language of delegitimation, relegitimation, and resistance in the interpersonal world of experience seems particularly apt in interpreting Mary Catherine Mullen's experience of chronic pain. Of course, the literature on chronic pain contains numerous accounts of the influence of family processes on the onset and course of symptoms. In fact, this is arguably the major causal pattern that behavioral psychologists diagnose and treat (Sternbach 1978; Turk et al. 1983). Psychoanalytically oriented practitioners and family researchers speak of the "gains" of illness and include in that category the explanation that pain and other chronic symptoms can restructure family relations and communication patterns, which clearly has taken place in Mrs. Mullen's household. Yet, the implication is often that either the circumstances are determinative as behavioral operants conditioning individual behavior, out of awareness of the sick person, or that there is a rational calculus by means of which individual decisions are made that reflect a shift in cost/benefit, a kind of malingering (see relevant chapter in Burrows et al. 1987 and also Turk et al. 1983). I find these implications unsatisfactory and am disturbed by the behaviorist language that would have us believe that Mrs. Mullen is either an ingenuous automaton or a blatant manipulator. Ten hours of interviews with Mrs. Mullen, corroborated by research and clinical work with many patients with chronic pain, make me greatly suspicious of the behaviorist discourse, which I find stereotyped, overly focused on pain as a problem of an *individual*, and dehumanizing.

In the perspective I have advanced in this essay, Mary Catherine Mullen is born into a delegitimated world. Illegitimate, abandoned by her mother, and raised by her grandmother in a family setting where she was viewed as tainted by her mother's sinful ways, Mary Catherine's early socialization disaffirmed her person and placed her in an anomalous relationship with her grandmother and others. She bore a sense of shame and also carried the idea that she was not good enough to receive her mother's love. When her mother precipitously removed her from her grandmother's home, she experienced a major loss and second transformation of her world. That transformation again encouraged an experience of delegitimation. Her mother abused her emotionally and physically. She also forced Mary Catherine to accept the name of the man to whom her mother was then married. For a while Mary Catherine had two family names: her mother's and her stepfather's. The confusion in identity was a simulacrum of her growing sense of tangentiality to her local world. In that world, she repeatedly heard her mother excoriate

her origin and personality. Disaffirmed and disaffected, she grew into adolescence feeling worthless. She felt a lack of efficacy with others and alienated from her family.

A common idiom of distress was her mother's headache. When her mother had headaches, which were frequent, Mary Catherine was expected to take care of the other children and her stepfather. Her mother's withdrawal and lack of affection were justified by the headaches, as were her irascible disposition and angry outbursts. Thus, Mary Catherine experienced headaches as a rhetoric of complaint for expressing hostility and controlling others.

The experience of delegitimation was reproduced in her relationship, in the early part of the marriage, with her husband. She seemed unable to control his drunken behavior and its violent consequences. She also seemed unable to effectively negotiate with him over their limited resources, much of which supported his alcohol abuse. After the birth of their daughter, she felt more intensely still the disaffirmation of her experience as wife and mother. Forced to move into her own mother's home, owing to her husband's failure as a provider, it appeared to her that she had come full circle to complete a lifelong cycle of despair. Mary Catherine's great obesity, about which she felt helpless and ashamed, became a bodily index of her alienated social status, a habitus structured out of the conflagration of stigmatized position, poor self-esteem, and a self-defeating sense of inefficacy in her local world. This alienation of habitus in turn structures the negative dispositions and interactions that perpetuate that world.

— The experience of pain in a world without security (in family, job, finances, or neighborhood) is what distinguishes chronic pain among the poor and the oppressed. When one cannot marshal resources, symbolic and instrumental, because they do not exist or one's access to them is obstructed, the very idea of control becomes untenable. The normal, everyday routinization of misery, furthermore, can be experienced as bodily pain. As a result, the confluence of this source of pain and bodily pathology makes it impossible for the afflicted person to determine what "causes" pain to worsen and what will limit or remove it. Pain cannot be made meaningful any more than can the rest of life. The absence of control as well as legitimacy means that to survive, those patients who lack resources yet are exposed to great pressures must conduct the moral equivalent of a life-and-death struggle. Pain, in such a local world, becomes the bodily component of so fundamental an experience of suffering that the local world becomes a world of suffering. Pushed up against the limits of control and meaning making, poor and oppressed patients may take up whatever is at hand to respond to adversity that can no longer be easily assigned to either medical or nonmedical sources. Thus, Mrs. Mullen's pain itself becomes a kind of solution, albeit compromised, to the consequences of suffering in her world.

The development of chronic pain, whatever its sources, sanctions a transformation in her experience. The pain becomes a means of resisting her husband's irresponsibility and her mother's cruel manipulations. Her sense that her world is not her own, that she has no central, secure place in it, is replaced by illness behavior through which Mrs. Mullen, with surprising energy and efficacy, moves to the center of that world and even comes to dominate its flow. The severe migraine headaches authorize a relegitimation of intersubjective experience. They are in fact emblems of a new way of engaging in the felt flow of experience. Mary Catherine Mullen's episodes of headache might even be thought of as a kind of social dissociation, from a hesitant, marginal orientation to her world, in which she is absorbed into the flow of practical actions effected by others, toward an assertive, central orientation, from which she reorients the flow of aggrieved sentiments and practices. The relegitimation of the world authorizes her access to the moral devices of accusation and restitution.<sup>11</sup> Of course, there is also evidence that Mrs. Mullen's resistance has certain negative effects, real and potential, such as expensive medical bills, unemployment, and perpetuation of a cycle of somatized distress and greatly disruptive explosions of rage into which her daughter may become the next conscript. Also, it is unclear how long such a newly invented ritual of behavioral reversal can keep going without straining the social ethos to the point of breakdown. For these reasons, it is difficult to know, at this point, if Mrs. Mullen's form of resistance in the politics of family and workaday world should be regarded as effective. What is more certain is that for poor working people from deprived backgrounds with few life chances and greatly limited resources, who lack reserves to respond to crises, even the dubious efficacy of embodied resistance may mean the difference between enduring and succumbing. In the exigency of routinized hurt and grievance and demoralization, simply not to continue to be overwhelmed may be a kind of desperate victory. Pain, like other forms of suffering, is resisted (Scott 1990).

### Case 3

An even clearer example of the possibilities and limits of the moral efficacy and practical experiential uses of resistance via chronic illness is provided by the research I have conducted in China among those deeply affected by the Cultural Revolution (Kleinman 1986; Kleinman and Kleinman 1991 in press). In this research, my colleagues and I encountered such frequent examples of neurasthenia symptoms sanctioning major changes in work and family and in relationship to the local Communist authority structure, we concluded that chronic, disabling bodily complaints were a chief source of power in Chinese work units. But it was also obvious that social categories of individuals—those with bad or good class backgrounds, women, youths who had been Red Guards—strongly influenced who had need for such power

and who could exercise it under particular conditions. Moreover, delegitimation meant something very different in the Chinese context. Our research subjects, like tens of millions of their Chinese compatriots, experienced the moral delegitimation of communism in the fiery chaos of the Cultural Revolution. Their local worlds, and the societal political system of which these are part, had lost moral legitimacy, and even the sources of social efficacy were undergoing dramatic change. Relegitimation has failed at the macro-social level in China, both through the brutal repression of the democracy movement and in the failure of the Chinese Communist party to reform. Yet, at the regional and local levels, various kinds of relegitimation efforts have occurred, with varying degrees of success. Hence, in Guangdong and Fujian provinces the economic reforms have continued virtually unchanged, whereas in other, poorer, more violated provinces a Communist counterreformation is underway. Most notably, in many work units and villages, there is a unified opposition to central and regional directives, and informing on others and collaborating with the entrenched political leaders are much less prevalent than during the Cultural Revolution. This is even the case, it seems, within the Communist party itself. In this sense, delegitimation of local moral authority is so pervasive that China can be said to be in the final stage of a cultural delegitimation crisis, even though it is uncertain what will follow.<sup>12</sup> Yet what is certain is that resistance through somatic symptoms and disability has not been an effective means for either expressing collective resistance or ushering in new forms in the local moral order. Even on the personal level it has been more self-defeating and socially unavailing than effective in reconstructing the flow of experience.<sup>13</sup>

For example, a middle-aged teacher in a rural town in Hunan had withdrawn into reclusive existence, mourning her losses in the political devastation of the whirlwind; under the authorization of her neurasthenic complaints, her withdrawal had no effect on the local political situation, but in fact worsened her family problems and deepened her own feeling of desolation. Another neurasthenic patient, a very competent Hunanese school administrator, carried her neurasthenic depression and pain as publicly recognized scars of her personal losses in the Cultural Revolution. Because of her complaints, she had been engaged in negotiations with the leaders of her work unit to either take early retirement or have removed an old cadre who blocked her administrative reforms. Yet her symptoms only made her situation more desperate and did not alter the political impasse in the work unit. A third sufferer of headaches, Huang Zhenyi, experienced a deeply humiliating personal trauma early in the Cultural Revolution, when as a young adolescent he was unjustly convicted of criticizing Chairman Mao. He had become obsessed with the bitterness of the injustice and was trapped in a self-defeating cycle of wishing to right a wrong on behalf of his "lost generation" while at the same time protecting himself from the machinery of politi-

cal repression. The result was a corrosive political silence replaced by louder and louder physical complaints that deepened his alienation. (These and other stories of Chinese survivors of the Cultural Revolution who suffered from neurasthenia are described at greater length in Kleinman 1986:105–142.)

#### THE LIMITS OF RESISTANCE AS AN ANTHROPOLOGICAL INTERPRETATION OF SUFFERING

Perhaps I have not done as full justice to the model of resistance as it deserves. Because the research I conducted in Boston involved the elicitation of personal and family narratives of pain and did not include participant observation, my access to local worlds of pain was constrained. This is an important constraint for an interpretation of the intersubjective flow of experience, inasmuch as I have had to assemble that interpretation from personal accounts and brief home visits with family members. In spite of this methodological restriction, I do feel this chapter contains evidence of the utility of the analytic framework in the anthropological study of the social course of chronic illness. Its chief value is as an operational device, which, as I have tried to illustrate, can facilitate analyses of the local mediation between microsocial psychological processes and the macrosociopolitical context. Parry and Bloch (1989:1–32) contend that the short-term cycle of transactions that individuals undergo parallels the long-term cycle of transactions at the societal level: together they *reproduce* cultural forms and social structures. In the perspective that I am advancing, the connection between these short- and long-term cycles occurs within the medium of a local world that situates person and family in an intersubjective space where moral order, affective ties, and bodily processes are integrated into a form of experience that has particular and shared features. The model of resistance, and the closely related concepts of delegitimation and relegitimation of moral worlds, offers only one perspective on this psychocultural mediation.<sup>14</sup> Yet, the limitation of this model, I believe, can be generalized to other anthropological approaches to the study of human suffering.

I characterize that limitation in the following terms. Just as anthropological accounts, such as those in this collection, fault biomedicine for its failure to respond to the teleological requirements of suffering—those existential and spiritual questions of what is most at stake in human experience that query the ultimate purpose of living—so, too, do culturalist accounts, which are so effective in diagnosing the inadequacy of natural science renditions of human conditions, fall prey to a type of social scientific transmogrification of suffering. Thus, interpreting chronic pain as resistance, or for that matter as discourse, gives primacy to the search for meaning over the rest of experience. The interpretive requirements of suffering for theodicy—namely, the

struggle of rebuilding a coherent account of why misery should exist in the world (see Weber 1978:518–529)—are viewed by many anthropologists as the core reality of suffering. But, as Vecna Das (in press) demonstrates in the tragedy-filled lives of Indian survivors of the Hindu-Sikh ethnic conflict and the Bhopal disaster, most of those who encounter deep suffering experience a chaotic, aleatory world. The wrenching process of having to bear the awful consequences of loss, menace, and the brutality of everyday deprivation are experienced not as theodicy but as terror and desolation and, for all too many, as the abulia of alienation. Whatever its particular features, the intersubjective experience of suffering is so various, so multileveled, so open to original inventions that interpreting it solely as an existential quest for meaning, or as disguised popular critique of dominant ideology, notwithstanding all the moral resonance of those foci, is inadequate. It may distort and eventually transmogrify this most deeply human of experiences.

For an ethnography of experience, the challenge is to describe the processual elaboration of the undergoing, the enduring, the bearing of pain (or loss or other tribulation) in the vital flow of intersubjective engagements in a particular local world. The ethnographer needs to fasten onto the overriding practical relevance of experience for those who engage in it, for whom something crucial is almost always at stake. At the same time, the ethnographer must struggle not to dehumanize the felt flow of lived experience through professional deconstructions that are totalistic and thereby claim an absolute, unpositioned knowledge of determinants and effects. Such an interpretation must be invalid because it denies the uncertainty and indeterminacy and sheer novelty of human engagements. Experience is emergent, not preformed. It changes. It goes on and on. The ethnographer must be cautious about creating an end that is artificial, an illusion of a finality that is not to be found in intersubjective space, where the echoes of embodied memories reverberate even after a death. The cultural constructionist's icon can be as inhumanely artifactual a characterization of experience, then, as is the pathologist's histological slide.

Properly deployed, the model of resistance must avoid these misuses and abuses of anthropological interpretation. That means that it probably can never be entirely satisfying as an explanatory account of human suffering. And perhaps that is as it should be. For when pain is configured as suffering, it evokes intractable, inexhaustible moral and spiritual questions that are worth pursuing to the extent we can better understand human conditions or provide assistance to sufferers, but which are as vulnerable to dehumanizing social scientific accounts as to biomedical ones. And here anthropologists of pain find themselves in an ethical position roughly similar to that of the clinician. For both, it is essential first to do no harm. For both, the moral requirement of engaging people who suffer is to struggle to transcend limited and limiting explanatory models so as to witness, to affirm, their humanity.

For both, there may come a time when, like the grieving author of the ancient *Lamentations over the Destruction of Sumer and Ur* (Mintz 1984:22), they need to admit, "There are no words!" It is in this spirit that I adumbrate resistance, delegitimation, and relegitimation of local worlds as *figures* to bring forward aspects out of the complex, collective *grounds* of chronic pain that have heretofore been obscured. This is yet another side of a subject that is best dealt with, not by insisting on a single "objective" interpretation, but by juxtaposing multiple, positioned, intersubjective perspectives.

#### NOTES

1. A considerable body of writing touches on aspects of this anthropological focus on the grounding of meaning and experience in local cultural worlds; see, for example, Abu-Lughod 1986; Geertz 1987; B. Good this volume; Hallowell 1967; Rosaldo 1980; Shweder and LeVine 1984; Stigler et al. 1990; Wikan 1980, 1989.
2. Schieffelin (1976), writing on the same ceremony among Kaluli but from a different theoretical perspective, has also presented a sensitive ethnographic description of this particular cultural construction of bereavement.
3. In this paragraph, I follow Bourdieu's (1989) usage of the terms *structure* and *structural* and *structuring*, but I will hereafter freely substitute the words *construction*, *constructed* and *constructing*, and *constitutive*, within the same general conceptualization of the generative dialectic in social processes.
4. The latter usage of resistance is expanded in Kleinman and Kleinman 1991 in press; the former usage builds on Scott (1976, 1985, 1990), who in turn appropriated the concept from an earlier, largely Marxist, generation of theoreticians, whom he also criticized; the idea of political resistance has been taken up in ethnographic works in which suffering and healing figure by Comaroff (1985); Ong (1987); Martin (1987); Taussig (1981) among others. Scott (1985) emphasizes peasant resistance in class struggles with wealthy villagers; his focus is on the everyday routines and extraordinary actions of participants in local moral worlds, who, among other things, engage in the politics of reputation and the implicit threat of violence to defend their vulnerable positions. Particularly pertinent is his argument that political economic decisions that mandate planned development undermine the established routines in local communities, so that the very moral structure itself is threatened, including the established patterns of interaction across classes. This places the poor at great risk and also threatens their legitimated coping devices. The analogy can be transferred to the health field to emphasize both the structural vulnerability of subordinate groups to local social changes that result from political economic change which in turn place greater pressure on the health status of the poor, and also as a means of highlighting, albeit provocatively, the increasing gap between the technological power and cognitive control of health professionals and the threat of increasing powerlessness felt by patients from the lowest socioeconomic stratum. Under these conditions, the patient-doctor relationship can become such an unequal engagement that poor patients find noncompliance one of their only ways of resisting paternalistic authority and asserting what little personal efficacy they believe to be available to them. The consequence, as Scott (1985, 1990) shows for the agricultural domain and political order

generally, may be to worsen their material conditions, yet the intention is to resist authority and to struggle for more control, symbolic and pragmatic. The same processes of resistance, I contend, occur in the therapeutic relationship and affect the moral economy of health. The political imagery will seem exaggerated and even inappropriate to many health-care providers and planners. Yet I would suggest that for at least some patients of poverty and perhaps for many others with chronic illness, the feeling that they are deploying "weapons of the weak" in unequal engagements both with the practical realities of health care and with those symbolic apparatuses that support society's "tyranny of health" which hold them responsible for their misfortune is neither irrational nor without its uses, particularly if the partisan language of class warfare is replaced by the experiential terminology of the ethnography of suffering.

5. For a useful discussion of embodiment of distress and disease from a phenomenological perspective, see Csordas 1990, whose discussion can be read as a complement to this operational description of suffering.

6. In the Jewish tradition, as Mintz (1984) discloses in his remarkable survey of responses to catastrophe in Hebrew language literature, writers have been torn by two questions that are highly relevant to the issues explored in this chapter. First, how should the suffering of the collective be portrayed? (Ever since *Lamentations* the device has been personification via the experience of particular individuals.) And second, how should unexplained and undeserved suffering be dealt with? The emphasis has been on cognitive disorientation and subsequent restoration of the paradigm of meaning (Mintz 1984:21). This meaning dominated concern with suffering, which has been so fateful for the Western tradition, periodically gave way, especially after the pogroms and the Holocaust, to a concern with resistance, as in Bialik's poem of rebuke of passive acceptance of oppression by Russian Jews following a pogrom, "In the City of Slaughter":

For since they have met pain with resignation  
And have made peace with shame,  
What shall avail thy consolation?  
They are too wretched to evoke thy scorn.  
(Mintz 1984:140)

The implication is that resistance is both authorized by undeserved suffering and the only morally justifiable response. Thus, the idea of resistance is charged with special moral significance in the Western tradition, a significance that echoes in Marx and in the writings of anthropologists who have picked up this question. This Western orientation toward suffering, especially as it has been refracted in the writings of existential authors, has, on self-reflection, clearly influenced my own contributions: first toward a meaning-centered medical anthropology, and more recently toward an anthropology of experience.

7. See Aaron Cicourel's tripartite model as described in Bourdieu (1989).

8. To protect the anonymity of the research subjects whose stories of pain I elicited, through five to ten hours of interviewing of each subject, I have changed identifying details and provided each subject with a pseudonym. The information contained in this chapter, though altered for this purpose, accurately conveys the essence of the research I conducted. When I have made changes to protect anonymity of patients and practitioners, I have drawn on findings from the entire group of the

chronic pain patients I interviewed in order to insure that the changes held general validity.

9. A full treatment needs to consider each of these aspects of pain. By focusing narrowly, I neither discount these other interpretations nor do I seek to contribute to a fallacy of misplaced concreteness. Resistance and delegitimation are components of a complex, contradictory, only incompletely understandable, positioned picture. I draw them out because others have paid insufficient attention to these moral sides of pain, and they support the larger conception of suffering I seek to develop.

10. I cannot here go further into the place of this religious implication of a fall from divine grace in the Hoff family's Huguenot tradition of Protestantism in Catholic France, but it is worth remembering that besides apostasy and forced uprooting, the spirit of resistance remained a strong component of the Huguenot's ethnic identity. Dr. Hoff's family took their religious tradition as serious business, and Hoff's building of her own career lends itself quite easily to the Weberian interpretation of the Calvinist roots of secular success. Hence, it would also seem appropriate to follow Weber further in his analysis of suffering as *resentment*, a critique of cultural authority from those below the established hierarchy or from those who, having fallen out of grace, take on a pariah status for which they seek retribution (Weber 1978:518-602). Furthermore, as Philip Hallie's (1979) study of how the French Huguenot village of Le Chambon saved Jews from the Nazis and their Vichy collaborators discloses, this tradition of Protestantism has supported political resistance of a remarkable quality, a tradition that Dr. Hoff's family prized.

11. In research with patients suffering from chronic fatigue syndrome in Boston, my colleague Norma Ware and I have noted that their exhaustion, once defined and sanctioned as a medical illness, though it frequently seems to be the result of exhausting life-styles, can also authorize basic shifts in the pace and control over activities in their local worlds. Some of these sick persons, most of whom are women, once they are diagnosed as chronic fatigue patients, make such fundamental decisions as changing or giving up jobs and intimate relationships, and end up transforming the very structure of their lives and even such daily social rhythms as when and how they sleep, eat, exercise, and spend their time. Illness, then, relegitimizes their flow of experience and reorganizes their engagements and transactions, authorizing greater control. Michel de Certeau (1984:43) avers that "everyday practices depend on a vast ensemble which is difficult to delimit but which we may originally designate as an ensemble of procedures." Our chronic fatigue patients, at least some of them, altered the "ensemble of procedures" and thereby everyday practices, too, through the experience of illness. I believe this can happen in chronic illness generally, including chronic pain.

12. The phases of this delegitimation crisis are several. During the Great Famine, from 1959 to 1961, when at least fifteen million Chinese and perhaps as many as twice that number died of starvation, hunger reached most Chinese families, yet the press dissimulated bountiful harvests, thus removing the possibility for effective public criticism that might support a challenge to the moral legitimacy of Communist party rule. The depredations of various antirightist campaigns and the chaos of the Cultural Revolution led to widespread private condemnation of Communist ideology and authority. This condemnation was such that in the period of economic reforms, from 1979 onward, the party itself switched its ideological justification for Communist rule

from the erstwhile class warfare to the new claim that communism had improved and would continue to improve the lives of most people, though it was admitted that 10 percent of the population still lived in abject poverty. This ideological reform was an attempt to shift the grounds for moral legitimacy to rule—what the Chinese have traditionally called the Mandate of Heaven—at a stage when massive cynicism had seeped into virtually every corner of the state. The Tiananmen massacre completed the delegitimation of the moral order. Mainland China today is ruled through military power alone without any vestige of cultural legitimacy. For the citizen in his family circle, delegitimation moved from passionate affirmation of Marxism to bitterly enervating disillusionment, and onward to involuntary compliance with discredited authority. Cynicism followed misplaced loyalty. Foot-dragging, false compliance, and passive hostility followed passionately prodigal political fervor and revolutionary ardor. The embodied effects of this trauma are deep and pervasive. (See Thurston 1987; Liang and Shapiro 1983; Cheng 1986; Liu 1990 among others.)

13. Perhaps the clearest North American example of pain as resistance to political authority that I came across in the chronic pain sample was a middle-aged lawyer from a suburban town who had arthritis in his hips and knees. Emile Sachar represented local working-class clients in negotiations with developers and the town authorities in a local dispute. Once his adversaries had recognized that Mr. Sachar's chronic condition worsened over the course of the day and required that he periodically get up, walk around, and even lie down, they pressed for meetings that lasted longer and longer, at which Mr. Sachar found himself sitting in chairs that lacked proper support. He felt certain that the behavior of his adversaries was aimed at worsening his complaints so that he would more readily agree to a compromise that favored their interests over that of his clients. Mr. Sachar responded by deliberately using his disability to authorize official delays in the negotiations. He also pointedly emphasized his pain and its effects on his posture and gait to gain a more sympathetic hearing for his clients' position and even to project the image that they were victims. The downside of this oppositional response, besides its limited tactical success, was the undermining effect the illness behavior had on Emile Sachar's personal life, including his marriage. Indeed, Mr. Sachar's demoralization seemed to arise as much from the social intensification of his disabled role as from his increasing despair over the possibilities for social justice in American society. Thus, like the Chinese patients whose neurasthenia had become the embodied scar of the Cultural Revolution, the bodily mode of resistance seemed to deepen personal crisis while not succeeding as a form of political protest or change.

14. For an alternative analysis of the cultural mediation of experience, see Jackson (1989:1–18).

#### REFERENCES CITED

- Abu-Lughod, L.  
1986 *Veiled sentiments: Honor and poetry in a bedouin society*. Berkeley, Los Angeles, London: University of California Press.

- Bourdieu, P.  
1977 *Outline of a theory of practice*. New York: Cambridge University Press.  
[1972]  
1989 Social space and symbolic power. *Sociological Theory* 7(1): 14–24.
- Burrows, G., et al., eds.  
1987 *Handbook for the management of chronic pain*. New York: Academic Press.
- Canguilhem, G.  
✓ 1989 *The normal and the pathological*. New York: Zone Press.  
[1966]
- Cassirer, E.  
1957 *The philosophy of symbolic forms*, vols. 1–3. New Haven, Conn.: Yale University Press.
- Cheng, N.  
1986 *Life and death in Shanghai*. New York: Grove Press.
- Comaroff, J.  
1985 *Body of power, spirit of resistance: The culture and history of a South African people*. Chicago: University of Chicago Press.
- Corbett, K. K.  
1986 Adding insult to injury: Cultural dimensions of frustration in the management of chronic back pain. Ph.D. diss., joint doctoral program in medical anthropology, University of California, Berkeley and San Francisco.
- Csordas, T.  
✓ 1990 Embodiment as a paradigm for anthropology. *Ethos* 18(1): 5–47.
- Das, V.  
In Press Moral orientations to suffering: Legitimation, power and healing. In *Health and social change*, L. C. Chen et al., eds.
- de Certeau, M.  
1984 *The practice of everyday life*. Berkeley, Los Angeles, London: University of California Press.
- Feld, S.  
1982 *Sound and sentiment: Birds, weeping, politics and song in Kaluli expression*. Philadelphia: University of Pennsylvania Press.
- Geertz, C.  
1987 *Local knowledge*. New York: Basic Books.
- Hallie, P.  
1979 *Lest innocent blood be shed*. New York: Harper & Row.
- Hallowell, A. I.  
1967 *Culture and experience*. Philadelphia: University of Pennsylvania Press.  
[1955]
- Hilbert, R. A.  
1984 The acultural dimension of chronic pain: Flawed reality construction and the problem of measuring. *Social Problems* 31(4): 365–378.
- Jackson, M.  
✓ 1989 *Paths toward a clearing: Radical empiricism and ethnographic inquiry*. Bloomington: Indiana University Press.

- Kleinman, A.  
 ✓ 1980 *Patients and healers in the context of culture*. Berkeley, Los Angeles, London: University of California Press.  
 1985 *Somatization*. In *Culture and depression*, A. Kleinman and B. Good, eds. Berkeley, Los Angeles, London: University of California Press.  
 → 1986 *Social origins of distress and disease: depression, neurasthenia, and pain in modern China*. New Haven, Conn.: Yale University Press.  
 ✓ 1988a *The illness narratives: Suffering, healing and the human condition*. New York: Basic Books.  
 / 1988b *Rethinking psychiatry: From cultural category to personal experience*. New York: Free Press.
- Kleinman, A., and J. Kleinman  
 ✓ In Press *Suffering and its professional transformations: Toward an ethnography of experience*. Paper presented at the First Conference on Psychological Anthropology, San Diego, 7 October 1989. *Culture, Medicine and Psychiatry*.
- Kotarba, J.  
 1983 *Chronic pain: Its social dimensions*. Beverly Hills, Calif.: Sage Publications.
- Liang, H., and J. Shapiro  
 1983 *Son of the revolution*. New York: Alfred A. Knopf.
- Liu, B. Y.  
 1990 *A higher kind of loyalty*. New York: Pantheon.
- Martin, E.  
 1987 *The woman in the body*. Boston: Beacon Press.
- Merleau-Ponty, M.  
 1962 *Phenomenology of perception*. London: Routledge & Kegan Paul.
- Mintz, A.  
 1984 *Hurban: Response to catastrophe in Hebrew literature*. New York: Columbia University Press.
- Newman, K.  
 1989 *Falling from grace: Downward social mobility in the American middle class*. New York: Random House.
- Ong, A.  
 1987 *Spirits of resistance and capitalist discipline: Factory women in Malaysia*. Albany, N. Y.: SUNY Press.
- Osterweis, M., et al., eds.  
 → 1986 *Pain and disability*. Washington, D.C.: National Academy Press.
- Parry, J., and M. Bloch  
 1989 Introduction. In *Money and the morality of exchange*. J. Parry and M. Bloch, eds. New York: Cambridge University Press.
- Plessner, H.  
 1970 *Laughing and crying: A study of the limits of human behavior*. Evanston, Ill.: Northwestern University Press.
- Plough, A. L.  
 1981 Medical technology and the crisis of experience. *Social Science and Medicine* 15F:89-101.

- Rosaldo, M.  
 1980 *Knowledge and power: Ilongot notions of self and social life*. Cambridge: Cambridge University Press.
- Scheler, M.  
 1971 *Man's place in nature*. Translated by H. Meyerhoff. New York: Noonday [1928] Press.
- Schieffelin, E.  
 1976 *The sorrow of the lonely and the burning of the dancers*. New York: St. Martin's Press.
- Scott, J. C.  
 1976 *The moral economy of the peasant: Subsistence and rebellion in Southeast Asia*. New Haven, Conn.: Yale University Press.  
 1985 *Weapons of the weak: Everyday forms of peasant resistance*. New Haven, Conn.: Yale University Press.  
 1990 *Domination and the arts of resistance: Hidden transcripts*. New Haven, Conn.: Yale University Press.
- Shweder, R., and R. LeVine, eds.  
 1984 *Culture theory*. New York: Cambridge University Press.
- Sternbach, R., ed.  
 1978 *The psychology of pain*. New York: Raven Press.
- Stigler, J. W., et al., eds.  
 1990 *Cultural psychology*. Cambridge: Cambridge University Press.
- Strauss, A., ed.  
 1970 *Where medicine fails*. New York: Transaction.
- Tambiah, S.  
 → 1990 *Magic, science, religion and the scope of rationality*. New York: Cambridge University Press.
- Taussig, M.  
 1980 *The devil and commodity fetishism in South America*. Chapel Hill: University of North Carolina Press.
- Thurston, A. F.  
 1987 *Enemies of the people: The ordeal of the intellectuals in China's Great Cultural Revolution*. New York: Alfred A. Knopf.
- Turk, D. C., et al.  
 1983 *Pain and behavioral medicine: A cognitive-behavioral perspective*. New York: Guilford Press.
- Weber, M.  
 1978 Theodicy, salvation and rebirth. In *Economy and society*, vol. 1, G. Roth and C. Wittich, eds., 518-529. Berkeley, Los Angeles, London: University of California Press. [1922]
- Wikan, U.  
 1980 *Life among the poor in Cairo*. London: Tavistock Publications.  
 1989 Illness from fright or soul loss: A North Balinese culture-bound syndrome? *Culture, Medicine and Psychiatry* 13(1): 25-50.