

6-21-2011

## Knowing is Half the Battle? Reflections on Myth, Metaphor, and the Untranslatability of Pain

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### Recommended Citation

Tsao, Eugenia (2011) "Knowing is Half the Battle? Reflections on Myth, Metaphor, and the Untranslatability of Pain," *Totem: The University of Western Ontario Journal of Anthropology*: Vol. 19: Iss. 1, Article 3.

Available at: <http://ir.lib.uwo.ca/totem/vol19/iss1/3>

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## Keywords

alienation, idioms of distress, meaning-making, mythology, pain, philosophy of communication, secularization, stigma

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## Knowing is Half the Battle? Reflections on Myth, Metaphor, and the Untranslatability of Pain

Eugenia Tsao

And the serpent  
Slipping between her gown and her smooth breasts  
Went writhing on, though imperceptible  
To the fevered woman's touch or sight, and breathed  
Viper's breath into her. The sinuous mass  
Became her collar of twisted gold, became  
The riband of her headdress. In her hair  
It twined itself, and slid around her body.  
While the infection first, like dew of poison  
Fallen on her, pervaded all her senses,  
Netting her bones in fire.  
(Virgil, Book VII: 480-490)

Several years ago, I found myself sitting by a window in a Toronto café, watching pedestrians flow by on a cool, rainy evening. I was working on a project about the cultural etiologies of eating disorders, and one of my chief arguments was that mainstream psychiatry's infatuation with biomolecular and neurochemical explanations for the disorder (which, at that time, were receiving considerable attention in the news media) served to conceal its intensely social and political dimensions. That night, the informant whom I was interviewing spent most of our chat stirring her tea thoughtfully, trying to find the words with which to describe the churning, trancelike pain of a bulimic episode. Visibly frustrated, Julia<sup>1</sup> found that she could portray the felt experience of bingeing and purging only in negations: it was not quite hypnotic, not quite ecstatic; exhausting but exhilarating; exhilarating but abominable, "and there is always fear, always," and ultimately it was none of these things at all. The language of predicate statements simply failed when called upon to communicate what it *was* to experience what she experienced. The contributions of the

vaunted clinical handbook, *Diagnostic and Statistical Manual of Mental Disorders* — "a dissociative quality"? "impaired control"? — were even less satisfying (American Psychiatric Association 2000:590).

As servers cleared the tables around us and began to upturn chairs in preparation for the café's closure, Julia leaned in, clucked her tongue, and posed a question of her own. Had I ever studied Classical literature? In response to my affirmative reply, she suggested that I reread the Roman scribe Virgil's epic poem *The Aeneid* and take the time to note the frequency with which the actions of its protagonists are said to be motivated by ruin, or folly, which slips organically into acts of hubris that provoke the gods and elicit divine retaliation. As Julia pointed out, the Hesperian queen Amata, whose inhabitation by the fury Allecto is described in the above epigraph, is never possessed *per se* — it is made clear throughout the poem that Amata is acting on her own initiative and that she is the author of her own downfall. Yet her decisions are invariably motivated by a concern for her people's best interests and, as a pawn in a cosmological drama with a predetermined outcome, the queen invites considerable sympathy. While she hangs herself in the final verses, unable to bear the sight of her burning city, audiences are enjoined to discern in her "sad frenzy" a kernel of hope (Virgil, Book XII:819), for hers is a unique kind of defeat: her city is not destroyed, but rebuilt and transformed into the seat of an infant Roman republic. Amata's story, Julia explained, was a subtle parable about the inter-dependence of pain, hope, risk, and fate that she saw as an irreducible feature of her condition. With a wry smirk, she noted that clinicians nonetheless viewed her tortuous identification with the Hesperian queen as a sort of delusion, a symptom of recalcitrant psychopathology that had to be dislodged. To her, existential pain was a

cardinal ingredient of life that she digested with the aid of rich allegories and mythologies; to her physicians, it was something that signalled irrationality and demanded banishment.

Anthropologists have long noted that a major casualty of biomedicine's cultural prestige has been respect for patients' firsthand experiences, which are routinely trivialized as idiosyncratic and "used in a condescending way by the expert as the raw material upon which to base diagnoses, generalizations, and theories" (Gabriel 2004:176). Firsthand experiences of pain, in particular, occupy a fraught place in the Western medical lexicon: inaccessible to third-party authorities, pain nonetheless plays a central role in diagnostic and prognostic reasoning and situates sufferers in the untenable space of being both an expert and an object of expertise. Oncologists, anaesthesiologists, and psychiatrists alike draw elaborate conclusions from their patients' descriptions of pain, and yet physicians regularly concede that the metrics they employ are not only quantitatively imprecise but qualitatively inadequate (Fishman 2009; Morris 1993; Pernick 1985). To study pain is to live vicariously, always guessing and never quite knowing if our own twinges, aches, longings, and pangs, and the rubrics through which we relate to them, can ever be mapped onto others'.

What is the epistemological significance of Julia's frustrations with her psychiatrists and ultimately with adjectival language itself? What contributions can anthropologists make to the enterprise of understanding the ontological value of pain to patients themselves, especially in instances when they are resistant to its medicalization? How might ethnographic studies of affect inform clinical and bioethical ones? In this paper, I strive to shed light on these questions by comparing

three distinct analytic frameworks concerning the subjective embodiment and intersubjective interpretation of pain: Robert Desjarlais' 1997 ethnography of mental illness and homelessness in Boston, Jean Jackson's 2003 essay on inpatients at a New England chronic pain hospice, and Gananath Obeyesekere's classic 1981 study of social stigma and spirit possession in eastern Sri Lanka. Each author makes a valuable contribution to a debate that has run the gauntlet of Western medicine for two centuries: to what extent is the pain of an individual person knowable by, and disclosable to, others? As I hope to reveal, while each approach has its deficits, a close reading of their overlapping insights brings into sharp relief the key role of metaphoric and idiomatic tools in making pain legible, and suggests that those who study pain too closely sometimes only contribute to its intensification.

Before proceeding further, three caveats must be established. Firstly, pain is conceptualized in the following pages not as physiological *nociception* — that is, the autonomic delivery of chemical impulses to the central nervous system that follows the reception of a material stimulus — but as a phenomenological experience. As Saris (1995:57-58) reminds us, pain is not a thing; it is an affective concept that we impose upon convergences of observations about ourselves, and cannot be quantified directly. Secondly, even in cultural contexts wherein the Cartesian preoccupation with mind/body distinctions is everywhere encoded, the body remains "the existential ground of culture," no more extricable from our experience of sentience and selfhood than our sensorial organs or perceptual faculties (Csordas 1990:5). Thirdly and consequently, "if emotionally caused pain is experienced physically, it *is* physical pain, no ifs, ands, or buts" (Jackson 2003:173).

*The medium is the message*

If emotional pain is physical pain, then why is communicating it so notoriously difficult? When attempting to recruit others' understanding, what techniques do people employ to translate their embodied pain experiences into verbal or nonverbal cues, and from what forms of reasoning do these techniques emerge? In his acclaimed ethnography *Shelter Blues: Sanity and Selfhood among the Homeless*, Robert Desjarlais (1997) suggests that in a culture like ours — which privileges the empirical and verifiable above all else — efforts to communicate pain are unusually susceptible to suspicion, disbelief, and trivialization. Those efforts, nonetheless, may be shaped by the very same forms of empirical logic that facilitate their trivialization.

As Desjarlais reveals (1997), due to a high rate of schizophrenia in the shelter population, staff members at the Boston's Station Street Shelter "found themselves working with a population that, they believed, often had to be brought back into the fold of the real" (192-193), and they laboured to explain to shelter residents that their claims of distress had to be based in forms of factually verifiable evidence or else they would be suspected of faking it. Rehabilitative programs for residents accordingly made use of an elaborate system of rewards and punishments designed to socialize residents into the communicative values of "lucidity, validity, accuracy, authenticity, and transparency of meaning" (Desjarlais 1997:194). Shelter personnel responded to residents' complaints of sundry aches, pains, and emotional hurts by evaluating their referential worth. Did the social workers' documentary records confirm a history of psychological distress, for example, or perhaps a pre-existing medical condition? Residents who wished to overcome the skepticisms of staff members had to ground their assertions in some form

of substantive evidence and would commonly direct staff to doctors' written testimonies. This system brought about a population of residents who were constantly preoccupied with innovating new ways to demonstrate to shelter personnel the authenticity and intensity of their distress. In some cases, residents sought to substantiate their pain by resorting to self-injurious practices (sometimes colloquially known as "cutting"), although this was routinely interpreted by shelter personnel as further evidence of psychopathology.

Desjarlais reframes the conflict between residents' and staff members' logics as a conflict between the empiricist infatuation with ontological-referential truth and the existentialist conception of truth as a personal construction. Some shelter residents responded to the empiricist imperative by playing up their physical ailments and downplaying their emotional ones: in contrast to feelings of misery or anxiety, which carried the risk of being deemed 'merely' psychological and possibly imagined or embellished, "toothaches and pinched nerves could carry an indisputable, self-felt presence that was usually hard to deny" (Desjarlais 1997:231-232). Many others, however, turned to self-injury as a vehicle for making undeniable the veracity of their dissatisfaction with society, the cards they'd been dealt in life, and the homeless shelter. By making "lasting, readable incisions" on their forearms (Desjarlais 1997:234), residents inserted themselves into a universe of meaning bound up in historically intelligible, if not always sanctioned, practices — tattoos, body piercings, slit wrists, scarification, Christ-like lacerations — and strove to inscribe irrefutable insignias of their pain into the most evidential canvas at their disposal: their bodies (see also Aretxaga 1995). In such instances, the 'proof of pain' that shelter personnel sought lay not only in

the mere presence of wounds and scars on residents' bodies, but in the very fact that these residents felt an urgent need to make visible — and make legible — their phenomenological pain.

### *When signifiers fail*

Desjarlais' arguments regarding the dilemmas that anguished people face in Enlightenment societies where their anguish is often deemed less-than-valid and not-quite-real are insightful, and his Goffmanian observations regarding the pathogenicity of institutional environments are often quite arresting. However, the utility of his analysis is limited in at least two ways. First, he begins and concludes his ethnography by asserting a questionable distinction between the mentally ill and the normal. Persons in the former category are, he says, "struggling along" rather than truly "experiencing," and are precluded from the full range of communicative faculties that the rest of us enjoy — hence their need to cut and scar in order to give voice to pain (Desjarlais 1997:10-24; 249). I would contend that the practices he observes in the shelter differ only in degree and method, rather than in genre, from the mentally 'normal.' Second, he seems to assume that self-injury can be motivated only by a desire to establish a line of communication. Presenting readers with a false dilemma, for instance, he asserts that his informants' self-injurious behaviour "was not due to any language-shattering inexpressibility inherent in the agony of pain or distress. It related, rather to questions of acknowledgement and recognition" (Desjarlais 1997:234). Given that he provides no rationale for ruling out the first of the two motives *prima facie*, one wonders why the two cannot coexist.

In her eloquent essay "Translating the Pain Experience," Jean Jackson (2003) takes the topic of 'language-shattering inexpressibility' more seriously by

considering the ways in which sufferers of severe chronic pain in New England's Commonwealth Pain Center (CPC) struggled to verbalize their experience of pain. Jackson's (2003:172) informants found it almost impossible to identify adjectives, symbols, or similes that adequately evoked what they felt. Many complained that however exhaustive their descriptions or visceral their comparisons (i.e., pain was likened to flashes of lightning, twisting daggers, searing heat, demonic possession, and lit blowtorches), the obscenity of their felt pain was such that it defied linguistic circumscription, especially given the paltriness of the referential lexicon available to them. As a result, while patients were "highly motivated to translate their pain by objectifying it...they realized that because such objectification distorted the experience, in a sense betrayed it, their translations were defective" (Jackson 2003:177), and many eventually became resistant to clinicians' solicitations of self-reflection. Moreover, their realization that their descriptions were being misinterpreted, pigeonholed into quantitative metrics, and even viewed as hyperbole by their clinicians led CPC patients to focus more attention on demonstrating that their pain had somatic *causes* and that their anguish was therefore legitimate, and less on expressing the pain itself.

While patients reported feeling isolated, trivialized, and betrayed by referential language, they also "felt compelled to commit to pin their hopes on it" and "continued to long for a language that promised distance, control, and abstraction precisely *because* representation is not coterminous with experience" (Jackson 2003:175-178, 183). Patients clung to language because language allowed them to intellectualize their aversive experiences in the same register as their clinicians, and thus to enlist empathy from those

empowered to legitimize their distress. However, while empathy is a start — unlike sympathy, it requires some mutuality of felt emotion — it is not equivalent to embodied understanding. In addition to the fact that medical clinicians routinely discredit ill people's capacities to speak rationally about their own illnesses (due not only to stereotyped concerns about the biases of firsthand experiencers, but to attributions to “secondary” and “tertiary” motives; see Sullivan 1995), in the rationalist intellectual tradition to which biomedicine is heir, observers are not supposed to participate in the phenomena they observe lest they lose their objectivity. One of the chief reasons why pain occupies an especially suspect space in the diagnostic lexicon is that it cannot be observed without the participation of the sufferer. As a result, Jackson observes:

Those who can produce authoritative translations ... not only are, by definition, non-experiencers, but, in addition, their job is to eliminate the experiential qualities of whatever malady lies behind the pain symptoms and replace them with observed, objective data — with signs rather than symptoms. Even though pain sufferers attempt to learn the professional's language, they will never be seen to speak it fluently, precisely because they experience pain. (Jackson 2003: 187)

In short, CPC patients felt that language was not only inadequate, it was also the handmaiden of a medical establishment that already had its own answers and solutions to the problem of chronic pain, ones that imposed standardized, precooked interpretations upon deeply private battles, and that unremittingly strove

to objectify — dissect, measure, calculate, determine causes of, find Latin terms for, and reduce into case histories — fluid experiences that revolted against objectification. Patients consequently lived out the anguishing paradox of yearning for some means by which they might successfully disclose the texture of their inexpressibly painful world in a way that preserved both accuracy and authority, while at the same time increasingly withdrawing from (and yearning for the freedom to fully abandon) the Sisyphean project of producing verbalizations fated invariably for misunderstanding.

### *Estrangement as engagement*

Jackson's account of the existential frustrations of chronic pain sufferers is nuanced and stirring, and her description of the relief that sufferers experienced in the presence of other sufferers who understood how hard it was to find words for pain's “preobjective and prelinguistic quality” (Jackson 2003: 183-184) raises compelling questions about the anaesthetic qualities of rapport. Pain, as Jackson reveals, effects a ferocious siege on language; when one has exhausted the conventionalized repertoire of tropes, similes, and allusions that one can summon to give shape to an excruciating experience, what remains is silence and isolation. Nonetheless, Jackson also slips a bit too easily into the assumption that the only reason distressed individuals engage in seemingly irrational practices is to legitimize their distress in the eyes of authorities (e.g. “abandoning attempts to translate a pain experience may constitute a step toward successfully communicating what the experience is like”, Jackson 2003:185). What of the significance of a person's refusal to speak of her pain experience — or her decision to harm herself, or discern a kindred spirit in Roman literature, or engage in whatever else might

serve, in her *own* eyes, as an emblem of her biographic travails — to herself? In particular, how might behaviours that are deemed ‘irrational’ in mainstream and medical discourses, such as neglecting one’s personal hygiene, actually represent methods of giving meaning to personal hardship?

It is here that I return to the question with which I began this essay. To what extent is an individual’s pain knowable by others? Contrary to the phenomenological position that Desjarlais and Jackson articulate, Wittgensteinian anthropologists and others within the post-analytic philosophical tradition have held that pain *must* be knowable by others in order to be knowable to experiencers themselves (Ulin 2001:46-62). However a person experiences a given torment, and whatsoever meanings materialize for her, those experiences and those meanings derive coherence from a cultural-linguistic heritage — myths, primordial symbols, narrative conventions, folkloric images, and the like — that is shared. In his work on “heteroglossic” speech genres, Mikhail Bakhtin (1999:121-124) has similarly argued that all semiotic productions carry with them the weight of their historical contexts of usage: a word or sign comes to mean a certain thing not because it has been defined thus *a priori*, but because all of the subjective ways in which it has been used in the past have converged to produce a specific, intersubjectively intelligible, contemporary meaning that is reconfirmed and refashioned every time a speaker evokes it.

The point is twofold. First, even preobjectified pain is not precultural; the ways in which people understand and give meaning to their pain are *both* internally produced and contextually derived. Second, while the histories of radical medicalization, demythologization, and secularization that pain symptoms/emblems have undergone in

our biomedicine-informed society have had the effect of masking their heteroglossic character, there always exists a symbolic grammar from which such symptoms and emblems emerge and take shape. What should interest the anthropological observer is not the somewhat tautological question of *what* performances of pain are meant to communicate, but *how* people learn to perform their pain in the way that they do.

In *Medusa’s Hair: An Essay on Personal Symbols and Religious Experience*, Gananath Obeyesekere (1981) advances a sophisticated exegesis of precisely this question, arguing that the classical anthropological distinction between ‘private’ and ‘public’ symbols fails to capture the dynamic ways in which signifier-signified relationships work within their contexts of use. As cultural productions, symbols invariably have significance on *both* individual and interpersonal levels: manifestations of pain are therefore simultaneously personal experiences and public performances. Through a close reading of the harrowing life narratives of “ecstatic priestesses and priests” who were once ordinary members of their communities, Obeyesekere (1981:169, 80-85, 77) explains that the dramatic idioms and imageries that enable their special status (e.g., pierced tongues, performances of trance and demonic possession, and especially the cultivation of filthily matted coils of hair) are not valorized in southeast Sri Lanka, but are, in fact, deeply stigmatized and often feared. This stigma, however, provides outcasts who are unable to achieve belonging within their families or communities with a durable identity that derives its durability not from inclusionary practices but rather exclusionary ones.

Obeyesekere is especially concerned with the meaning of matted hair, which elicits both anxiety and awe within the Sri Lankan mainstream, caught as it is between

the countervailing imperatives of concern for hygiene and uneasy respect for the religious guilds into which pariahs congregate. The phenomenon conjoins three questions. How did matted hair become such a rich signifier? What does matted hair represent to wearers themselves? What does it represent to observers, and from what cultural logics does this message derive coherence? By considering the ways in which people's growth of messy, tangled coils of hair is linked with painful and humiliating life experiences (e.g., the loss of familial love, a futile search for belonging, the repeated appearance of a divine figure in one's dreams, the renunciation of conjugal love, and "the god's gift for having renounced *eros* for *agape*... matted hair," Obeyesekere 1981:33, 88), Obeyesekere contends that some hardships can be so psychically painful and beyond the capacity of the individual to consciously subdue, that they demand materialization in the form of alienation. Individuals in pain may need their community's repudiation to understand their own pain even if, or especially when, those communities will not help them *out* of their pain. As a symbol, matted hair is strongly associated in Sri Lanka with filth, physical duress, a lack of sanitation, and the revulsion such things elicit within the wearer's community — and thus, a "special and redoubtable" status for the person making the transition from frightened outcast to frightful icon (Obeyesekere 1981:35-37, 63).

Three distinctions are of particular significance within Obeyesekere's thesis. The first is between a "living" symbol and a "nonliving" one, the former of which requires its users to *voluntarily* "create it each time on the anvil of their person anguish," lest it lose its coherence in the public eye; the latter of which exists only in inert texts (Obeyesekere 1981:33, 37-8). The second is between a "symbol" and a

"symptom," the former of which operates to encode its bearer as a unique being; the latter, simply "a somatic manifestation of a psychic or physical malady" acquired through disease or neglect (Obeyesekere 1981:37). The third is between a "myth model" and a "fantasy," the former of which involves a person's use of mythic tropes "to produce, and thereafter justify, innovative acts, meanings, or images that help express the personal needs and fantasies of individuals"; the latter, an expression of desire that does not necessarily make use of wider mythologies (Obeyesekere 1981:84, 123, 136-137). In all cases, the fulcrum of the distinction is, in essence, the tension between idiom and idiosyncrasy — the first has a clear and irreducible meaning within a local context of use, while the second does not — and, in Sri Lanka, outcasts who bear filthy, snarled dreadlocks are not seen as dishevelled psychotics but as potential clerics. The fact that a person is feared and alienated by his community does not necessarily mean that he has been severed from their universe of meaning. As Obeyesekere suggests, stigmatization may eschew cultural boundaries, but psychiatrization is a peculiarly Western fetish:

Thus a Sri Lankan patient afflicted by a *preta* [demon] can behave in any number of seemingly bizarre yet recognized ways and, like a Western psychotic, act out his or her troubled emotions. But such behaviour is in fact not considered bizarre: it is readily understood as the work of a *preta*, not only by the culture but also by the patient. The question of private and idiosyncratic behaviour does not arise: that is a Western conception arising from the decoding and demythologizing of symbols. The

personal (not private) experiences of the patient are readily intelligible through the myth model; and the myth model is revitalized and rendered real by the personal behaviour of the patient. (Obeyesekere 1981:101)

The notion — so heavily advertised in our medicalized society — that pain *only* destroys and isolates is belied by the extensive narratological work that a wide range of people put into making sense of anguish, discovering value in their torment, and, in so doing, refashioning their social identities to accommodate rather than deny their suffering and stigma. If in *our* society it has become difficult, even unfathomable, for mainstream audiences to sanction or salute the refashioned identities of individuals who cannot escape their pain and so enshrine it, we may wish to ask ourselves why that is.

### ***The things we do for love***

On the outskirts of every agony sits some observant fellow who points. (Woolf 1931:205)

Pain is no indelible mystery, at least not to anyone who has experienced it. As Desjarlais, Jackson, and Obeyesekere each deftly demonstrate, the concept tethers a vast landscape of signs, scripts, and iconographies that each communicate some aspect of what it feels like. It can be vulgar and heaving; irresistibly violent; or chronic, cruel, and whispering. It can be emotionally felt and physically manifested, or vice versa. On the surface, therefore, the question of whether or not pain can be communicated to others is at least a little bit disingenuous, because the answer is: of course it can.

But evoking shared imageries and patterns of synonymy to give voice to one's suffering is no guarantee of understanding, let alone knowability. In circumstances wherein social roles are available to help a "person afflicted with mental illness,

tension, or turmoil to cope with his estrangement" (Obeyesekere 1981:103-104), it is possible for pain to be understood by both oneself and one's observers as a coherent, meaningful — even redemptive — experience. However, for those of us who inhabit a society that has secularized demons and cashiered them from its behavioural landscape, pain is a barren destination and a source of relentless misconception. Unable to establish common ground with clinicians and denied opportunities to carve out roles for themselves in the social tapestry, Desjarlais' schizophrenic self-injurers and Jackson's chronic pain sufferers are exiled twice over: first by their ineffable pain, and again by the probing callipers of the social workers, doctors, and administrators who confect their expressions of pain into well-defined, neatly manicured lines of data.

Melford Spiro (1990), borrowing a phrase from T.S. Eliot, once observed that the task of anthropology is to make the strange familiar and the familiar strange. Rather than claiming to be disinterested discoverers of objective knowledge, modern anthropologists have indeed consistently sought to reveal the ways in which knowledge — all knowledge, whether scholarly, folk, sacred, or secular — is actively produced by individuals who are situated in and shaped by particular times and places. Over the past decade, our discipline has seen a florescence of research on war, displacement, migration, urbanization, and postcolonialism, demonstrating how crucial it is for us to take seriously the firsthand knowledges of people who have survived unique blows, and to honour the symbolic and spatial tools they deploy to manage the warp and woof of their traumas. Anthropologists studying the politics of marginality have increasingly identified key places for pain as a point of analytic departure: rage and heartache can become determining forces in people's lives

when historical injustices remain uncorrected (Livingston 2009), and the problem is exacerbated when mainstream onlookers fail to grasp, honour, or heed “the ways that past violence inhabits the present” (Langford 2009:705). However, making these insights evident and pedagogically useful to a wider range of research communities will take more work. In our society, biomedicine is a dominant force in trauma research, and its discourses and practices carry considerable weight even among anthropologists who labour to reveal the history behind prim medical theories (Breslau 2004; Lock and Nguyen 2010; Tsao 2009).

In a neoliberalizing climate that increasingly views quality of life in terms of workplace productivity, economic profitability, legal responsibility, and pharmaceutical pliability, the frameworks that researchers impart upon pain have significant practical effects: they trivialize and pathologize some people’s expressions of self, and they valorize others’. To challenge the rise of scientific models that take for granted the notion that suffering is largely rooted in chemical imbalances and congenital predispositions, many anthropologists have levelled powerful counter-arguments that correctly and conscientiously shed light on the class inequalities and other socioeconomic factors that have major effects on health (Baer, Singer, and Susser 2003; Dressler 2010). Indeed, as multidisciplinary researchers, anthropologists are especially well-situated to raise questions about the latent assumptions that inform investigations in multiple areas of scholarship, and the steps we’ve taken in this regard have been very heartening. At the same time, an unintended consequence of this trend has been a bit of over-eagerness to assign cost-benefit rationales to self-destructive choices (cf. some researchers’ insistence that anorexics starve themselves

solely to fulfill social expectations or that sex workers are inevitably motivated by financial desperation; see Gooldin 2008 and Leclerc-Madlala 2003 for reviews of these positions), a move that elides the subtle philosophical inducements that some see in their pain, stigmatization, and exile. As Wardlow (2006:23) notes, studies that axiomatically treat individuals’ actions as ancillary to their socioeconomic settings can end up erasing their personal agency — their capacity and right to prefer to be “wayward” when understanding is absent and acceptance seems impossible.

What is the upshot of all of this? Within a biomedical culture that is heavily informed by economic variables, pain is embodied deviance: an irregularity that marks a particular body as something other than optimally productive/normal, and therefore an irresistible site of empirical inquiry. Pain that seems to lack a material origin is not just deviance; it is delusion. In this context, “denying an audience to someone who wishes to narrate their pain is as much a violation as forcing a pain discourse on someone intent on silencing it” (Gabriel 2004:180), and the dual violation reveals an uncomfortable dilemma. The semiotic resources that people mobilize to fashion themselves into survivors of adversity tap insistently into larger conflict narratives — the conquest of Hesperia, Sri Lankan demon dramas, or the Book of Job, the persecution of Shylock, the siege of Troy, the demise of Camelot, and countless other fragments of folklore, both ancient and modern — that are anchored in sophisticated constructions of grief, futility, anguish, weariness, regret, outrage, betrayal, tragedy, and despair. These constructions, however, do not have a place in diagnostic parlance or laboratorial practices, which brandish “a special technical status based on objectivity and standardization independent of society and culture” (Lock and Nguyen 2010:53).

Pain, ultimately, has become untranslatable through unsparing processes of rationalization and medicalization that treat folk knowledges, in all their messiness and mutability, as inauthentic forms of knowledge. Yet pain, while rarely chosen, does not invariably defile, and there are times when searching for empirical causes and assigning stable definitions to suffering distorts the experiences of those who suffer.

### Acknowledgements

This essay has been facilitated by a research grant from the Social Sciences and Humanities Research Council of Canada. I am indebted to Professor Holly Wardlow of the University of Toronto for her input on an early draft of this paper. I am also deeply grateful to two anonymous reviewers at the University of Western Ontario for their helpful feedback.

### Notes

<sup>1</sup>The name is a pseudonym. In the interests of ensuring anonymity, identifying details about this encounter have been elided or disguised. Ethical clearance for this project was granted in February 2006 under the provisions of an undergraduate course on qualitative research methods.

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