

Stigma, liminality, and chronic pain:

Mind–body borderlands

ABSTRACT

In this article, I employ the concept of “liminality” to answer the question, why is pain, something invisible and experienced by everyone, so often stigmatizing in its chronic form? Various authors’ work on liminality argues that “betwixt and between,” ambiguous beings are seen by those around them to threaten prevailing definitions of the social order. I show that certain features of chronic pain result in the perception of sufferers as transgressing the categorical divisions between mind and body and as confounding the codes of morality surrounding sickness and health, turning them into liminal creatures whose uncertain ontological status provokes stigmatizing reactions in others. [*chronic pain, liminality, mind–body dualism, stigma, medical anthropology*]

In 1986, while doing ethnographic research with chronic pain sufferers at a multidisciplinary pain center, I was struck by the number of patients who reported feeling stigmatized. They felt that this treatment was unjust and often spoke with fellow patients and staff about why friends, family, and health professionals behaved toward them in such fashion. During their stay at the center (here called Commonwealth Pain Center, or CPC), patients individually and collectively made efforts to heal the feelings of self-blame and unworthiness resulting from interactions they experienced as stigmatizing. But I also heard patients themselves employing stigmatizing language behind one another’s backs, sometimes using the very same labels they had been subjected to outside the center. In addition, at times staff deliberately engaged in stigmatizing actions aimed at provoking certain patients into changing their attitudes and behavior. These examples of stigmatization present a puzzle: Why is pain, something invisible and experienced by everyone—and therefore unlike the kinds of characteristics that usually lead to stigmatization—so often stigmatizing in its chronic form?

I argue here that certain features of chronic pain can result in sufferers being seen to transgress the categorical division between mind and body and to confound the codes of morality surrounding sickness and health. As a consequence, they threaten the normal routines of biomedical treatment and the expectations governing ordinary face-to-face interactions between individuals labeled “sick” and other members of their social world. I examine the similarities between these sufferers’ ambiguous status and the status of liminal objects, states, and beings in various “exotic” societies that challenge the logic of dualistic classification systems. Various authors’ work on liminality argues that transitional states and ambiguous beings and objects, being neither one thing nor another, are disturbing and threatening; I argue that chronic pain sufferers’ liminal status invests them with similar threatening powers.

The situation faced by sufferers of chronic pain allows exposure of certain fault lines of the dominant positivist and Cartesian understandings

of selfhood and the human body as they have been institutionalized in U.S. biomedicine.¹ Constructing this kind of anthropological critique allows understanding of chronic pain stigma as a process in which chronic pain, by profoundly challenging mind–body dualism, presents a dilemma that turns the person embodying that dilemma, the chronic pain sufferer, into a sublimely liminal creature whose uncertain ontological status provokes stigmatizing reactions in others.

Although the concept of “chronic” pain might seem fairly straightforward—symptoms that persist beyond expected healing time (Loeser 1991a:213)—in fact, its complex meanings are highly contested within pain medicine. For the purposes of this article, I define pain as an aversive feeling experienced in the body that cannot be measured directly.² Its status as a medical symptom, rather than a sign, means that doubts may arise about degree of intensity (e.g., “You’re making a mountain out of a molehill”) or even reality. Defining chronic pain is even more complicated because, although pain is commonly seen as a symptom rather than a disease (a “normal” indication of something abnormal), chronic pain has lost this function and is itself the problem. Another complication is that the distinctions between the experience of pain, pain behavior (any behavior seen to result from a pain experience), and certain emotional states seen to often accompany, rather than constitute, pain (such as suffering, depression, or demoralization) can be, and often are, highly ambiguous.³ Chronic pain’s chronicity—that it never ends—means that it is accorded less legitimacy than acute conditions, for, as Talcott Parsons (1958) points out, the sick role is legitimate only for a period of time. Finally, some chronic pain sufferers may be seen to resist getting better because they are unconsciously motivated by benefits obtained by being ill—known as “secondary gain.”

As used here, *liminality* refers to two distinct, albeit related notions. The first, as originally formulated by Victor Turner (following Arnold van Gennep), concerns a stage in a process of change that creates a limen (threshold), thereby introducing the possibility of moving to a new structure or back into the old. Turner notes that “[a] coincidence of opposite processes and notions in a single representation characterizes the peculiar unity of the liminal: that which is neither this nor that, and yet is both” (1964:99). Liminal people or entities elude or slip “through the network of classifications that normally locate states and positions in cultural space. Liminal entities are neither here nor there; they are betwixt and between the positions assigned and arrayed by law, custom, convention, and ceremonial” (Turner 1969:95).

The second notion has been developed by Mary Douglas and other authors and derives from Emile Durkheim’s work on classification concerned with “matter out of place,” or “category mixing.” Some of this work examines

the pollution that can attach to beings and objects that fail to fit into the classificatory categories society constructs. Although Turner discusses how negative affect can become associated with liminal beings and states, he does not explore dirt and pollution per se. For reasons of simplicity I use the notion of “liminality” to cover both senses, “betwixt and between” and “matter out of place.”

The notion of “liminality” has been extremely productive in anthropology. For example, Gilbert Lewis (1975) applies the concept to the sick role in the Sepik River (New Guinea) society he studied; as the sick are transitional between two normal social states, health and death, they are liminal beings.⁴ Lewis sees the liminal phase of taking on the sick role to involve a separation from normal social life and the acquisition by the sick person of a negative aura. More recently, Niko Besnier (1994:287), analyzing gender liminality in Polynesia, employs three characteristics of Turner’s scheme: a “betwixt and between” locus, an outsider status, and social inferiority. Liisa Malkki’s research on refugees in Tanzania utilizes both meanings of liminality. Malkki discusses the ways refugees inhabit a liminal space because they are at a stage at which they (theoretically, at least) could go forward or back. She also analyzes the ways in which refugees are “matter out of place” (Malkki 1995:6), challenging a categorical system—in this case, one dealing with national identity. That refugees are considered “meaningful primarily as an aberration of categories and an object of ‘therapeutic interventions’ ” (Malkki 1992:34; see also Malkki 1995) resonates strongly with the chronic-pain case examined here.⁵

Although not all cases of liminality are perceived negatively—sometimes liminal beings and stages are seen as sacred or as representing hope—liminality is positively valued only when society provides a special status or role for the liminal object, state, or being. Pnina Werbner (2001: 140–141) discusses the way the ashes scattered over people by masqueraders during certain Moroccan rituals are, in fact, bringing blessings, for on departing, the masqueraders carry the dirt and pollution of the old year with them. Western society, however, has not assigned a special role or status to chronic pain sufferers, and they are viewed negatively.⁶ This is especially true of sufferers the medical establishment sees as not entirely entitled to their pain: Either they are seen not to deserve their disability payments or their acceptance of such payments is seen to be countertherapeutic. An example of the latter is the CPC director’s blunt statement that “people paid to be in pain do not improve.”

During its 17 years of operation, CPC, a separate 21-bed inpatient unit in a private nonprofit rehabilitation hospital in New England, offered a multidisciplinary, one-month program geared to reducing severe chronic pain and teaching skills for coping with it. Treatment involved a team approach that focused on conservative, noninvasive

medical therapies; cognitive therapies; social services; group psychotherapy; and one-on-one psychiatric therapy. The main goals of CPC (and many similar centers around the country at the time) were to eliminate the source of pain when feasible, teach patients their limitations, improve pain control, end medication dependency, and treat underlying depression and insomnia. CPC also addressed issues of secondary gain, worked to improve family and community support systems, and, in general, endeavored to return patients to functional and productive lives. My research there lasted from February 1986 to February 1987 and included eight months observing and interacting with 173 resident patients. I conducted 196 interviews with 136 patients (60 were interviewed twice) and interviewed 20 staff members. The CPC ended its inpatient program two years after I completed the research.

CPC staff members viewed some patients as entering with “real” physical problems and overlays of depression or “pain habits.” Others were admitted whose pain was originally attributed to an organic problem (e.g., the result of an automobile accident) that no longer appeared to account for much of the current problem. Finally, some patients came on the unit with mysterious pain problems; in these cases staff, with only clues and hunches to go on, used tactics patients often considered prying and provocative to make a more comprehensive diagnosis. Because the center focused on improving pain management, no patients were admitted to the unit with “uncomplicated” chronic pain (e.g., caused by arthritis or osteoporosis) that they handled reasonably well. The unit was founded in 1972 and at the time of my work there had evaluated more than 4,000 chronic pain sufferers, half of whom had been admitted as patients. In 1985, CPC’s patient population was 58 percent female and 42 percent male, the average age was 45.2 years, and pain duration averaged 76.2 months. About half of the patients were receiving some form of employment compensation. The majority of patients suffered from lower back pain; next in frequency were headaches and neck pain, followed by complaints of facial, chest, arm, and abdominal pain.

The reader should understand that this article is not directly concerned with the center’s staff, therapeutic program, or patient responses to it. I analyze CPC’s program elsewhere (Jackson 1994a, 2000) and mention it only as it relates to the issues being addressed here. Neither should the article’s object of study be construed as the field of pain medicine, in general. The issues addressed here are grounded in ethnographic fieldwork conducted at a particular site at a specific time. References to the pain-medicine literature are intended to contextualize the CPC setting and provide a sense of the debates on chronic pain at the time of research and their evolution to the present.

The rest of the article is structured in the following manner: The next section discusses the liminal status of

pain medicine within medicine. The section that follows briefly surveys the relevant social science literature on stigma, and the one after that looks at the nature of chronic-pain stigma in more detail. An argument linking stigma, chronic pain, and liminality in comprehensive fashion comprises the next section. Conclusions follow.

The liminality of pain medicine

Passionate debates over how to define chronic pain and how to reach a consensus about etiology and treatment have occupied a significant amount of space in the pain-treatment literature ever since the specialty of pain medicine emerged during the 1960s and 1970s. Pain specialist John D. Loeser’s astute point that “pain is not a thing; it is a concept that we impose upon a set of observations of ourselves and others” (1996:102) helps explain the debate, as the observations are made by a rather heterogeneous aggregate of researchers and clinicians.

Clearly, anyone interested in mining for cases of liminality is guaranteed to find a mother lode in pain medicine. The following quotes, listed chronologically, give a sense of the range of opinions about how pain is to be defined.

To classify certain types of pain as “psychogenic” pain is purely arbitrary, because all pain is a psychic perception (Livingston 1976:70). [Kugelmann 1997:48]

Psychogenic pain feels just like pain (Merskey and Spear 1967). [Sullivan 1998:200]

The [chronic pain] patients are deceiving themselves. They believe—really believe—that they are in pain, but they aren’t; they do not actually feel any pain. [Matson 1985:67]

It appears [Howard Rachlin] is suggesting that the person “feeling” but not “showing” pain is simply in error. . . . So that if one wishes to determine accurately whether he is in pain, he should do something like look in a mirror to determine whether he is showing behavioral signs of pain. [Genest 1985:60]

Those pains which never evince behavior, Rachlin is prepared to dismiss as illusions. . . . The existence of such internal mechanisms and processes is indubitable. And truth is preferable to ideological purity. [Foss 1985:59]

It is widely agreed among clinicians treating pain problems that there are at least two kinds of pain. . . . The categories are usually referred to as acute and chronic or nociceptive [*sic*] and psychological or . . . sensory and operant. [Jaynes 1985:61]

One pain is enough. [Matson 1985:67]

But it is not clear that this entitles him to say that there are two *kinds* of pain or that there are two *components* of pain. [Miles 1985:69]

[Pain is] ... a Cartesian dualism by its subdivision ... into “sensory” and “psychological.” This is an intellectual artifice invented to preserve a concept of divided brain and mind ... there is not a scrap of physiological or psychological data to support the dualism. [Wall 1985:73]

The distinctions between sensory and psychological, cognitive, physiological, and behavioral are not conducive to an increase in our understanding of the problem of pain. In fact, they have created our dilemma. [Loeser 1985:65]

Let us consider the first dichotomy that has led to confusion in the field: Pain is a sensory experience, and everything else—emotion, motivation, thought, evaluation, coping strategy—is the reaction to the sensory experience. ... This approach leads to confusion. [Melzack 1985:67]

I proposed that pain experience comprises a number of dimensions that reflect activities in parallel processing systems. [Melzack 1985:67]

There are really two continuums of pain: one consists of degrees of emotional pain, and the other of levels of intensity of physical pain. These strands are dynamically related and interact in various ways in a single pain experience. [Encandela 1993:786]

John Loeser said it succinctly: “Psychopathology is an oxymoron.” We only look to psychology to explain symptoms when tissue pathology has failed us. And psychological lesions are precisely those without evidence in tissue pathology. [Sullivan 1998:200]

The currently received concept of pain perception as objective nociception becoming subjective pain is incoherent in the classically Cartesian way. [Sullivan 2001:149]⁷

These quotes suggest that the highly contested definition of pain itself is a major reason why defining chronic pain as symptoms that persist beyond expected healing time, although true, does not take one very far.⁸ No wonder Chris Eccleston and colleagues comment that “chronic pain creates a challenge to orthodox and accepted understandings of illness and medicine” (1997:707). No wonder Robert Kugelmann comments that “chronic pain as an entity finds its very existence disputed” (1999:1665), and

“the question of pain is not in what category to classify it, for the categories themselves are freighted with philosophical presuppositions, not labels for pre-existing things” (2000:306).

In addition to theoretical debates in the literature, sociological studies of pain clinics reveal widely divergent treatment approaches informed by different definitions of chronic pain. In an article published in 1992 reporting on research on 25 pain-treatment facilities in the same urban area as CPC, Thomas J. Csordas and Jack A. Clark describe remarkable diversity in virtually every aspect of pain treatment, characterizing the pain centers as attempting “to resolve a fundamental medical anomaly through clinical practice” (1992:384). Mariet Vrancken’s (1989) empirical study of eight pain centers in the Netherlands found five distinct approaches: somatico-technical, dualistic body oriented, behaviorist, phenomenological, and consciousness. In their study of interactions between chronic-pain patient and physician, Beatrice Priel and colleagues (1991:65) found that treatment approaches could be grouped in terms of a focus on psychoanalytical principles, overt behaviors, psychophysiological reactions, and cognitive responses. Finally, Eccleston and colleagues (1997:704–706) found significantly different etiologic models in a sample of pain professionals and pain scientists.⁹

Ronald Melzack and Patrick Wall’s gate-control theory of pain, published in 1965, constituted a successful challenge to the specificity model of pain perception (which sees pain, in Melzack’s [1986] words, as “a specific sensation and the intensity of pain is proportional to the extent of tissue damage” [Sullivan 1996:208]) by providing a physiological model of how both central and peripheral nervous systems can modulate pain.¹⁰ Although their theory, the first to fully incorporate psychological and physiological processes, represented a paradigm shift—it was very quickly and very widely accepted (Kugelmann 1997: 52)—the prevailing etiologic models did not merge into a single orthodox theory. Not by a long shot.¹¹

A very brief and partial run-through of each of the three predominant etiologic models follows.

The biomedical model

As already noted, the biomedical perspective sees chronic pain as a process that transforms pain, originally a symptom of a lesion, into the problem itself. Melanie Thernstrom (2001), a journalist, describes how this process produces abnormal changes in the brain and spinal cord, unleashes a cascade of negative hormones, and causes other pathological changes that can be documented with blood tests and brain-imaging technologies like positron emission tomography (PET) scans. She notes that clinicians who see pain itself as the culprit speak metaphorically of broken alarm systems, hormones, and surgical mistakes.

Another biomedical example is Harold Merskey's suggestion that a persistent pain might appear after a number of injuries or operations—the result of “anomalous activity in the nervous system, a dysfunction *originating at the neuronal level* rather than a change triggered by a large variety of possible psychological or psychosocial causes” (2004:69).

The difficulties with the biomedical model applied to persistent pain have been comprehensively discussed in the pain literature.¹² Obviously, a major problem is the conflict between physiology and psychology. Ann Gamsa's (1994) sharply critical appraisal of the literature on the role of psychological factors in chronic pain reveals extensive disagreements among authors. She critiques assumptions that pain is caused by either organic or psychological factors, that pain that does not correspond to known physical pathology is psychological in origin, and that patients with undiagnosed intractable pain are a psychologically homogeneous group. She also complains about simplistic dualistic conceptions and linear causal explanations.¹³

Isabelle Baszanger, discussing pain specialists' fruitless attempts to achieve consensus in diagnostic labeling, cites one classificatory system that distinguishes between “chronic benign nonneoplastic pain” (which may involve “continuous acute pain”) and “chronic intractable benign pain syndrome” (1998:91)—a distinction that would seem to be *prima facie* evidence of a terminological tar baby. The way the classification scheme discussed by Baszanger distinguishes between the two types of chronic pain—“the patient's capacity to cope adequately”—reveals the core component of pain medicine's *de facto* definition of chronic pain.

In fact, chronic pain has come to mean a disorder that virtually requires the absence of tissue damage—even though some authors are careful to speak in terms of an apparent absence of tissue damage. Kugelmann states that chronic pain has characteristically served as a default category: “The diagnosis seems to have been a dumping ground for types of pain not easily assimilated to the sensation [i.e., specificity] theory” (1997:48).¹⁴

The depth psychology model

A psychodynamic perspective explains problematic chronic-pain conditions in terms of hysteria (conversion), somatization (a somatic expression of unresolved psychic conflict), hypochondriasis, or as caused by a “pain-prone” personality.¹⁵ This perspective examines the role of deep-seated emotions, early experiences of abuse, depression, and the like.¹⁶ Diagnosing phantom limb pain as an unconscious grieving for the lost limb is an example of this explanatory model. Quibbling over diagnostic terminology is found in abundance, for example, in Merskey's comment that some authors prefer to call pain caused by

hysteria “psychogenic regional pain . . . operant pain . . . or abnormal illness behaviour” (1984:64).

Adherents to a rigidly psychoanalytical version of this perspective are decreasing in number, in part because of cogent criticism and in part because of advances in knowledge and development of diagnostic tools that have revealed organic causes for conditions previously seen as psychologically caused.¹⁷ In a recent publication, Merskey (2004:68) questions whether pain as a hysterical symptom actually exists—a shift from his previous position.¹⁸ “Weighty evidence,” he states, is now available showing that most pain diagnosed as lacking tissue damage is, in fact, caused by “soft tissue disorders” and similar organic factors. Using words like *somatizer* or *somatizing*, he warns, is increasingly dangerous.¹⁹ He also complains about tendencies to see “behavioural activities” that very likely have resulted from the chronic illness as evidence of a personality problem that caused the disorder (Merskey 2004:69).²⁰

In particular, the notion of “pain-prone personality” has been heavily criticized.²¹ Gillian A. Bendelow and Simon J. Williams hold that this notion may be to blame for “the categorization of pain lacking well-defined physiological causes as ‘imaginary’ with inevitable stigmatising consequences” (1995:143).

Operant-conditioning and behavioral–cognitive models

Operant conditioning's best-known proponent, pain specialist Wilbert Fordyce, argues that, rather than see pain the way the disease model sees it—as a symptom—clinicians should be asking, “Why is this person emitting suffering or pain behaviors?” For Fordyce, “Pain behaviors are interesting social communications, the meanings of which remain to be discovered in the individual case,” and he adds that “people who have something better to do don't suffer as much” (1988:282). As is apparent from the quotes presented at the beginning of this section, behavioral theorists argue that there are two kinds of pain, “sensory” (“respondent”) pain and “psychological” (“operant”) pain, and that both are overt behaviors (i.e., neither is an inner process or state). The operant-conditioning model “does not concern itself with pain, an internal subjective experience, but rather with overt manifestations of pain and suffering—‘pain behaviors’ ” (Turk and Rudy 1992:101).²² In sum, this model sees chronic pain as a learned response that persists because it is reinforced by benefits, or rewards, that accrue to the pain patient. According to Julian Jaynes, calling chronic pain an operant means that it is always fulfilling some purpose of the patient: “either getting sympathy or a pension, avoiding work or war, reenacting a hurt-child–caring-parent relationship in surrogate, getting noticed by nurses or family, feeling important with important-sounding medicines or . . . obtaining medication, particularly narcotics” (1985:61).

Proponents of the operant-conditioning model have been criticized for saying that clinicians' most important task is to eliminate pain behavior, the underlying experience of pain being secondary, even insignificant. "If there were no pain behavior, there would be no pain problem . . . the essence of the problem is that there is pain behavior" (Fordyce 1978:54).²³ Taken literally, this means that treatment should not depend on diagnosis and alleviation of pain, but on extinguishing behavior patterns; what the patient might be experiencing is of little consequence as long as those feelings are not made apparent. Kugelman, critiquing this position, says, "Pain is, by implication, either meaningless or correctly meaningful only when it is not socially disruptive" (1997:58).²⁴

Cognitive-behavioral medicine, although clearly deriving from behavioral psychology, differs from the hard-core behavioral model in several important respects. Numerous cognitive-behavioral clinicians accept that pain behavior can signal the effects of social reinforcement. But they do not agree with Fordyce's proposition that in the absence of pain behavior there is no pain problem. Whereas the "pure" operant-conditioning model only seeks to eliminate pain behaviors and reinforce "well behaviors," the cognitive-behavioral approach also seeks to modify the experienced meaning of pain.²⁵ Treatment approaches include therapeutic modalities other than operant-behavioral ones, such as learning relaxation or bio-feedback techniques, self-monitoring of environmental stress, and developing cognitive coping skills.

An attempt at synthesis

I have shown that confusions and debates over several kinds of dualisms continue to create significant stumbling blocks for pain-medicine researchers and clinicians. What follows is a list of the main ones. Of course, the dualisms are interconnected; I tease them apart for purposes of analysis and subsequent synthesis.

One source of confusion is illustrated by William Livingston's (1976) observation cited above: failure to distinguish pain the experience ("all pain is a psychic perception") from pain characterized in terms of cause (e.g., psychogenic pain).

A second source of confusion derives from unsuccessful attempts to incorporate experience and feeling into a basically biomedical model. Whereas many pain researchers agree with the definition supplied by the International Association for the Study of Pain, Subcommittee on Taxonomy that pain is "an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage" (1979:249), others clearly dislike having to conceptualize pain in subjective terms (see Hardcastle 1999). Nowhere is this confusion more glaring than in debates about the possibility of "painless pain." On one level a purely se-

mantic dispute ("obviously a meaningless term" [Melzack 1985:67]), on another level the debate provides a window through which one sees the profound mind-body dilemma that pain presents.²⁶ In 1963, K. Jaspers complained that, although pain specialists subscribing to the "pain as symptom of nociception" model may agree that pain is psychological, in practice they use a physical notion of pain "since they are aware of physical events within the body that form part of the mechanism of production of pain. Thus doctors make contradictory remarks like, 'Severe pains need not be felt' " (Merskey 1985:68). Four years later, Merskey and Spear (1967) criticized tendencies to confuse a physiological event (nerve impulse) with a psychological one (pain), which, according to Kugelman, led to two problematic situations:

- (1) denying that pain exists when a person says it does, simply because there is no physiological evidence for it (phantom limb pain was the primary example);
- (2) attributing pain to a wounded person who denies feeling it. Thus [in Merskey and Spear's (1967:61-62) words] "to call pain which is primarily related to physical disturbances 'organic' and other pain 'psychogenic' can thus be inconvenient and even illogical." [1997:55]

Yet as recently as 1998, John Liebeskind, a highly respected pain researcher, argued that pain can be experienced "with absolutely no emotion" (Perspectives 1998:185).

Often the issue is couched in terms of cause and effect: Pain is a physical stimulus that produces an emotional response. For example: "As such, pain is responded to by behaviors and attitudes learned by pain sufferers within the cultures in which they are socialized" (Encandela 1993:783). Sullivan turns this notion on its head: "What is given to us first and foremost is not a determinate sensation of pain but a form of life in which pain has a specific place" (1995:7), and "pain is experienced in terms of the pain concept; it is not experienced raw and then interpreted conceptually" (1995:9).

Finally, disagreements exist about the relationship between pain and behavior. Given that behaviorists like Howard Rachlin see both "sensory" and "psychological" pain to be overt behaviors, Myles Genest (1985:60) asks whether one should then conclude that patients are largely mistaken about their own pain levels and that trained observers know better.

Melzack, who has no trouble seeing pain as an inner state, addresses this issue:

The second major dichotomy that has led to confusion . . . is the variable link between experience and behavior. As long as we recognize that pain is not simply a reflex response to injury but that a complex brain intervenes between input and output . . . the

brain is the repository of our fears and anxieties, our understanding of the situation. . . . It is for this reason that the link between pain experience and behavior is so variable. [1985:67–68]

In sum, there continues to be no universally accepted definition of pain. In my opinion, Howard Fields (in press) goes a long way in resolving the particular bones of contention discussed above. He notes that all pain experience results from activating a neural representation in the brain, which projects the representation “in space to the site of tissue injury” (Fields in press). This means that nothing outside the brain is capable of hurting. The pain “is physical pain in the sense that nerve cells and their activity are physical. It is mental pain in the sense that it is subjectively experienced ‘in’ what we generally call the mind” (Fields in press). He also discusses three distinct components of pain: a purely discriminative part, a motivational aspect, and an evaluative aspect, each of which takes place in different parts of the brain (Fields in press).²⁷ The pain experience itself, argues Merskey, “is monistic, which, at least as a rule, cannot be split up into organic or psychological components” (2004:71). Fields makes the same point: “What most people call mental, or emotional pain is ontologically identical to what they call organic, physical or bodily pain. This point is counter-intuitive and failure to appreciate it has compounded the confusion about the nature of pain” (in press).²⁸ Finally, that there can be dual or multiple causes of pain should be obvious (see Jackson 1994b).

The characterizations provided above help one understand why chronic pain, especially in its “intractable” form—note that *intractable* simply means “unresponsive to treatment”—seemingly so easily defined as pain that lasts and lasts, is in clinical practice a deeply ambiguous and fraught concept. Certain additional factors further complicate the picture. To begin with, the field of pain medicine treats a wide variety of painful conditions, variously caused by viruses (e.g., postherpetic neuralgia), neurological dysfunction (e.g., causalgia), cancer, and so forth.²⁹ At the time of my research many multidisciplinary pain clinics typically offered a wide range of treatment modalities, which could include various kinds of physiotherapies, pain medications and antidepressants, surgery, psychotherapy, and biofeedback and other kinds of relaxation techniques.³⁰

A related factor lies in the divergence between the medical specialties that treat the bulk of chronic pain cases—orthopedic surgery, neurology and neurosurgery, anesthesiology, and psychiatry. These specialties have developed out of very different roots, occupy very different niches in the medical establishment, and are characterized by very different institutional cultures. Csordas and Clark found substantial variety in their study of pain

centers in a single urban area. In some centers diagnoses were largely psychologically framed (e.g., one director said that all of his patients suffered from “chronic pain syndrome” [Csordas and Clark 1992:390]), whereas in others psychological and psychiatric diagnoses were virtually absent (Csordas and Clark 1992:389).³¹ One director characterized the chronic pain syndrome diagnosis as a “basket term” used by physicians when they could not make a specific diagnosis of a puzzling pain problem (Csordas and Clark 1992:390). When patients who had been admitted to a pain center were referred to a facility that espoused the other approach, they were almost invariably rediagnosed (Csordas and Clark 1992:389).

In addition, no overall consensus exists regarding pain medication. Whereas many pain-treatment specialists worry about overmedication, others bemoan the undermedication of patients, and successful lawsuits charging undermedication have been mounted.³² The polarized debates on this matter appearing in the mass media and medical and legal journals at the time of research and at present provide ample evidence of passionate and widely diverging views.

Another complication is that, despite a great deal of effort expended on finding correlations between personality variables and chronic pain and, thus, a typical “pain-center patient” (Gamsa calls this “the uniformity myth” [1994:22]), candidates for pain centers constituted a very heterogeneous population at the time of my research and continue to do so.

Finally, as must be clear by now, chronic pain patients rather easily fall out of the category of patients physicians are eager to treat and into the category of being “a pain” themselves—a “crock” (see Gamsa 1994:23; Gordon 1983). Relations between pain patients and health care deliverers are considered the worst in medicine. In fact, pain patients can provoke an intense hostility in caregivers, often the result of a relationship that has seriously deteriorated.³³ Frustrations mentioned in the pain literature include the simple fact of the practitioner’s failure; noncompliant patients; patients who “shop” for doctors with liberal pain-medication prescription policies; patients who obtain pain medications from more than one physician; and patients who clearly need to be weaned from the health care delivery system.

As indicated above, individuals’ perceived entitlement to the sick role or medical treatment or financial compensation can vary substantially. Included in the collectivity of chronic pain sufferers (estimated to contain 30 million to 50 million Americans; Thernstrom 2001) are the following degrees of entitlement.³⁴ Most deserving are people who have experienced tragic events that seriously damaged their bodies (e.g., someone riding in a car that was rear-ended by another car). These sufferers’ moral status is impeccable, for they are seen to have in no way deserved

their fate. Less deserving are people who are seen to be responsible to some degree for their current situation—for example, someone who dove into a pool at midnight on a dare and ended up a paraplegic. Another group contains people whose neuroses are seen to produce or augment their continuing pain. Their mental “weaknesses” disqualify them from membership in the first group because their pain’s cause lies within them, and from the second group because the cause is located in their unconscious. Finally, individuals who knowingly misrepresent the degree of impairment they have sustained are seen as morally reprehensible malingerers. Whereas people in the second group are seen as responsible but not deeply blameworthy and those in the third group are viewed as mentally weak people whose problem is beyond their control, members of this last group may be spoken of as outright criminals who should be prosecuted for fraud. Unfortunately, the means for assigning individual patients to a specific category can be so uncertain that teams of clinicians in pain centers sometimes find themselves in heated disagreement during evaluation meetings (see Corbett 1986; Loeser 1996).

Stigma

According to Edward E. Jones and colleagues (1984), the process of stigmatization contains several stages.³⁵ The first, categorization and generalization, consists of the stigmatizers (Erving Goffman [1963] refers to them as the “markers”) lumping the people who share the feature that elicits stigmatization (what Goffman calls the “mark”) into a group and projecting onto these people certain other basic personal characteristics, as well. Fairly superficial features come to indicate more fundamental traits that are seen to lead to deviant behavior, traits that constitute deficiencies of character. One can see stigmatization, therefore, as an extreme form of categorical inference. The stigmatization process can often engulf the identity of the individual because the objectionable characteristics attributed become highly salient. The strong, primarily negative affect that results represents the most crucial component of the stigmatization process. Quite often the stigmatizers realize that the evidence available does not justify their negative reactions and come to see some of the process as arbitrary. When this happens, guilt and sympathy mingle with the primary feelings of aversion or revulsion, and another very common feature of stigma—ambivalence—appears.

Work in the social and behavioral sciences has analyzed stigma from four perspectives. The first, and best known, is concerned with management—how to deal with the effects of being stigmatized. Several decades ago Goffman (1963) noted that stigmatization processes often produce “spoiled” selves that have to learn how to man-

age their “spoiled identities” in face-to-face interaction. Social labeling, the second perspective, is a kind of self-fulfilling prophecy in which merely classifying a person into a certain category has a performative effect, turning the person into a self-perceived member of that category. A related process, “secondary deviance,” occurs when markables (people with marks) come to behave in deviant fashion as a result of labeling—living up to their reputation, as it were.³⁶ The third perspective looks at the way stigmatization, or the threat of it, functions as a mechanism of social control that motivates marked people to act as normally as they can and that encourages unmarked people to stay in line by illustrating the dire consequences of not doing so. The fourth and final perspective, also functionalist and the main one employed in this article, sees the hostile reactions to people with marks to be a consequence of their being perceived as a challenge to the prevailing definitions of the social order. Markables somehow pose a threat to community well-being. The credibility of such reasoning is established by demonstrating links between the mark and danger. This perspective holds that stigmatization occurs because it achieves social purposes such as affirming the values of the in-group, displaying its superiority, enhancing its solidarity, and reconfirming its power to define, to exclude, and to punish.

Jones and his collaborators (1984) argue that this fourth perspective includes a folk explanatory model known as the “just world” hypothesis. The model explains why certain people experience major illness, impairment, and other catastrophes and others do not by asserting that such misfortunes are somehow deserved. This “blame-the-victim” model’s ubiquitousness probably stems from the fact that most people simply find it too difficult or too threatening to accept that serious accidents or illnesses “just happen” and so will demand some kind of explanation, however far-fetched. Even when the victim is oneself, a nagging suspicion may surface that one somehow deserves one’s tribulations. Note that the word *pain* itself derives from *poena*, Latin for “punishment.”

Chronic pain: Mind–body borderlands and stigma

As noted, chronic pain itself, being an experience and invisible, is not stigmatizing in the way “deviant behavior or appearance linked directly to the diagnosis . . . can evoke fear or disgust, as might occur in the lives of someone with psoriasis, seizures, or a harelip” (Lennon et al. 1989:119, 122).³⁷ In the chronic pain case, the “deviant behavior or appearance” is much more nebulous than, say, the behavior of someone with Tourette’s syndrome. The main source of stigmatization in chronic pain is inappropriate pain behavior. An additional source is the pain sufferer’s existential situation, as the unendingness of someone’s

pain clearly can evoke anxiety and similar negative reactions in others. Ironically, as I show below, the lack of a visible mark is considered by some pain sufferers to create the conditions for stigmatization.

Severe chronic pain is delegitimized in several ways, all serving to question the pain's reality. First, chronic pain does not fit into notions about the nature of pain (we have all had pain, but our pain went away), and, therefore, those who experience persistent pain "fall out of culture," as R. A. Hilbert (1984) puts it. Noel Edwards, a migraine sufferer at CPC said, "It's difficult to understand what it's like to have a headache for three years. It's never stopped . . . it's easy to be taken for a hypochondriac."³⁸ The unending quality of chronic pain makes communicating about it problematic because, although one expects behavior such as crying or grimacing to accompany the sensation of pain, one also expects such behavior to end, sooner or later. Many pain sufferers report being baffled about how to communicate about their pain day in and day out, and some say this endeavor is more challenging than dealing with the pain itself. Rachel Murphy said, "You feel that [people] don't want to hear it and you're depressing them about your problems. So you're better off not to say a word."

Another delegitimizing process, a kind of "mountain-out-of-a-molehill" response, asserts that because everyone has aches and pains, the sufferer, especially if male, needs to stop being childish, self-indulgent, and weak; rather, he should "pull himself together" and "keep a stiff upper lip."

The most complex delegitimizing process focuses on the possibility that psychological factors are at play. When pain is defined as psychogenic, the sufferer may be seen as not having a "real" illness or "real" pain (see Jackson 1992). Both CPC staff and patients often contrasted "real" (organic, physical) pain and "all-in-your-head" (imaginary, mental, emotional, or psychosomatic) pain. Virtually all of the patients I interviewed had struggled with doubts—both self-doubt and others' doubts—about the organicity of their pain.³⁹ Although most recently admitted patients saw their problem in terms of "real" pain with "real" causes, challenges mounted by staff and fellow patients regarding the degree to which that pain was, in fact, "real" often increased patients' anxieties about how others saw them. Because pain is invisible and unmeasurable, some of the patients whose cases were not crystal clear asserted that they would have preferred having a known problem, even a serious one. Sandra Glynn reported that her very visible delight at hearing her doctor say, "Sandra, you absolutely have a problem," resulted in his looking at her as though she "had four heads." Cancer was preferable, I was told more than once, because it is a known diagnosis with treatment possibilities. Saying that one would prefer cancer carried significantly more force in 1986 than it would today.

Suggestions to patients about psychogenic inputs invited worry about being seen as mentally ill, which undoubtedly is a major reason why people involved in chronic pain—sufferers, their families, and primary care physicians—are so often invested in seeing pain in mechanical terms: the archetypical lighted match under a finger. For the majority, any suggestion of mediation by the mind is seen to decrease the organic quality of a pain experience, thereby increasing its potentially stigmatizing quality. When "real" pain is seen as simple physiological communication about tissue damage from an external input or about an internal organ malfunction, one has an uncomplicated model that challenges neither conventional notions about the separation between the body and mind nor ideas about who deserves sympathy for bodily injury.⁴⁰ Seeing pain as an experience felt by an individual with a personal history who is embedded in a social and cultural milieu—surely the way to conceptualize it (see Morris 1991; Zborowski 1952, 1969; Zola 1966)—admits the possibility that the sufferer might have somehow "brought it on him or herself" to some extent.

Conventional notions about psychogenic inputs fit into this issue of "bringing it on oneself" in a complex fashion. When pain sufferers are seen to gain in some way from the pain, they may be perceived as partly responsible for producing it. Three kinds of gain are distinguished in the clinical literature. Primary gain diverts the patient's attention from a more disturbing problem (Hahn 1995:26). Secondary gain, as noted above, is the interpersonal or environmental advantage supplied by a symptom(s). Tertiary gain involves someone other than the patient seeking or achieving gains from the patient's illness (Bokan et al. 1981:331). Primary gain, an unconscious process, cannot logically be associated with much responsibility on the sufferer's part, but, as Laurence Kirmayer (1988:71, 81) points out, although psychiatric disorder may not be seen as "someone's fault," the personhood of the sufferer is diminished: He or she is seen as mentally weak. In contrast, discussions in the literature (and at CPC) about secondary gain often have an aura of "crazy like a fox" hovering around their edges; use of phrases like "accident neurosis" and "cured by a verdict" (referring to litigation following automobile or other accidents that secure monetary damages—also known as "green-poultice medicine") are examples (see Guest and Drummond 1992; Mendelson 1992; Osterweis et al. 1987; Satel 1995; Weighill 1983). These phrases imply that while litigation is in progress pain sufferers "hold onto their pain" to obtain hefty settlements. Pain sufferers' frequent comments such as "All I know is, I didn't want to have this pain" are responses to this kind of insinuation.

As secondary and tertiary gain are seen to be closer to conscious processes, achieving insight into them is considered possible, and considerable pressure was applied

to patients at clinics like CPC (at the time of my research and up to the present) to get them to understand that such psychological processes might be contributing to their problem and to accept partial responsibility for their condition. Note that both kinds of assessments—the diminished personhood associated with primary gain and the responsibility associated with secondary gain—are stigmatizing.

At CPC, the combination of patients' steadfast belief that physical causes constituted the intrinsic meaning of their pain and the high degree of stigma attached to "all-in-your-head" pain meant that they often resisted discussions occurring in therapeutic encounters about, for instance, the connections between pain and consciousness, or about how to influence the pain experience by deploying cognitive modalities such as pain imaging (in which patients imagine their pain as an object, creature, or person). Because pain considered to result from nonphysical causes is stigmatizing, patients often found it difficult to talk about their pain as a psychological experience.

Returning to the literature on stigma, Jones and colleagues (1984) discuss the location of various kinds of markables along three dimensions. The first dimension is concerned with the visibility of the deviant mark, in particular, whether or not it can be concealed. As pain is invisible (see Scarry 1985), one must infer its presence from observations of others' bodies or behavior. Questions arise about whether and to what degree pain behavior results from a conscious choice, an unconscious choice, or no choice at all (e.g., a prosodic scream). Such questions form the basis for a good deal of research. But, given that chronic pain sufferers can usually successfully hide what they are feeling, one can conclude that most communication about chronic pain involves some degree of intention. Pain behavior can be an attempt to communicate about the experience of pain or about other feelings associated with the pain experience (such as suffering, demoralization, etc.). Separating the pain experience from experiences accompanying it is a demanding, perhaps impossible, task and constitutes another reason why sufferers find that making their pain apparent can invite doubt and suspicion.⁴¹ When asked whether pain sufferers could correctly infer how much pain other people experienced, CPC patient Edgar Leger answered that at least half of them are able to "spot the phonies."

The possibility of significant discrepancy between pain experienced and pain communicated is a major source of the stigma and alienation many sufferers report. Wendy Caton complained that a boyfriend thought she would not, rather than could not, go jogging. And Edward Valliant griped that

the problem that I had on the outside was, every time someone heard that I had a back problem, or that I

had been hurt at work, or that I was on disability, [they would say] "Aw, you got it made." You know, "There's nothing really wrong with you, you got it made. You can just sit back now and collect your money and lay around all day and sit in the shade." The whole bit about having someone tell you, "You got it made," that fires me.

Although some people with visible marks would prefer a concealable condition, chronic pain sufferers sometimes bemoan the invisibility of their pain, saying they would prefer a more visible—even though also stigmatized—condition. Teresa Gilman said she would rather be missing a leg because then people would say, "That person has a disability, there's something wrong with that person," whereas people with chronic back pain and head injuries can look perfectly normal. And Wendy said that if she had a cast on her leg or a pacemaker, her friends would not ask her to go jogging. The pacemaker, although not visible, would be "real" and would account more successfully than her pain for her having to limit her activity. The cancer that some said they would rather have is also "real," even though often invisible and stigmatized.⁴² Lennon and colleagues (1989:126) found that seven out of ten people in their sample of facial pain sufferers said they sometimes wished others could see their pain.⁴³

Pain's invisibility allows sufferers to dissemble. Only someone with a concealable mark could say, as Franklin Austin did, that, despite desperately wanting to stand up, he sat through his university classes because he did not want to disturb anyone. Such concealment, of course, does nothing to legitimize the pain, but it partially relegitimizes the sufferer as a person in his or her own eyes. As Lennon and colleagues (1989:120) point out, however, "passing" as someone without pain can be isolating because the concealer is aware that she or he is secretly different from others (see also Hilbert 1984:371–373). As Dora Hatch said, "I'm such a phony, I laugh, I smile." In the end, the invisibility of chronic pain puts sufferers in a bind: sooner or later they must affirm the presence of pain with some kind of pain behavior, but, for the most part, such behavior elicits sympathy only at first.

The second dimension of stigmatization discussed by Jones and colleagues (1984) has to do with the extent of social disruption produced by the mark. Chronic pain is socially disruptive only under certain circumstances. The clinical literature concerned with this issue usually speaks of the disruption in terms of costs—loss of productivity, excessive disability payments, drains on the health care system (see Osterweis et al. 1987). Such goals have motivated some authors to criticize behavioral approaches to treating chronic pain as examples of social control, insofar as they serve the needs of others (the physician, the family, or the economy) more than of the sufferer (see, e.g.,

Finerman and Bennett 1995; Kotarba and Seidel 1984). Clearly, determining who has the authority to define “well behavior” or “acceptable levels of health behavior” is a point of contention among a diverse group of stakeholders.

Pain sufferers’ changed lives may result in negative sanctions insofar as their pain behavior challenges prevailing definitions of the social order, in particular, the issue of who is entitled to the sick role. Pain sufferers may feel especially hurt by these negative sanctions because non-pain sufferers who judge certain kinds of pain behavior (e.g., going on disability) to be a source of social disruption are most often the sufferers’ intimate friends, family members, and health care professionals, all of whom are normally expected to be sympathetic and caring. Many CPC patients reported feeling estranged from and misunderstood by their intimates and physicians. As Karl Hill said, “After a while, no one believes you, not even my wife.” Kenny Fonseca, whose pain followed a stroke 11 years previously, spoke of his family laughing at him. Lennon and colleagues conclude, “Thus, paradoxically, while the stigmatized may rely more [than people without marks] on close ties, the qualities of these ties may suffer under the strain of managing a potentially stigmatizing condition” (1989:121). Sufferers rely on biomedical experts to validate their claims of discomfort but find that, “ironically, for many with chronic pain, the treatment-seeking that was conducted in order to achieve legitimacy can contribute to feelings of stigmatization” (Lennon et al. 1989:120). When one considers that medicine is probably the most authoritative institution in the United States, the negative effects of experiencing stigmatization by health care professionals may be as powerful as if biomedical practitioners actually were an in-group purposefully delegitimizing an out-group.

Note that, although sufferers resent the doubting attitudes of others, they concede that pain’s invisibility allows them to amplify, or outright lie about, degree of suffering. Several CPC patients reported that at times they had exaggerated or somehow misrepresented the severity of their pain. Here is Edward again: “It depended on who you were with. Some understood that pain was worse some times than others, so it wouldn’t bother me to show when it was better. On the other hand, I certainly didn’t want to tell the doctor I was feeling better because then he wouldn’t give me the prescriptions.” He also spoke about how he sometimes used his pain inappropriately in interactions with his family, in particular, his wife; for example, whenever she complained that they never went out anymore, he “hobbled” as though in a lot of pain, and she ceased nagging him.

The third dimension discussed by Jones and colleagues (1984) concerns whether the mark is aesthetically displeasing. Pain, being invisible, does not itself displease the observer, but pain behavior might. And pain behavior

is extremely interesting in this regard, for it is displeasing only when judged inappropriate to the occasion or when the person exhibiting such behavior is thought to be “giving in to the pain,” or exaggerating. Overall, negative aesthetic evaluation of pain behavior seems to utterly depend on the ascribed meaning of the behavior within a given context, for pain behavior can elicit either great sympathy (as do depictions of the suffering Christ on the cross) or great opprobrium.

Limiting consideration to chronic pain, what observers find aesthetically pleasing is the absence of pain behavior. CPC patients spoke of admiring fellow patients who “suffered with dignity” in a manner that behavioral pain specialists would approve of. Fred commented that although Scott Theriault, a fellow patient, was in terrible pain (“he’s got more pain than I’d even think of having”), he just “grins and bears it. If he can grin and bear it, I should be able to.” Note that Fred’s joking “even think of having” plays with the imaginary pain issue. Kirmayer (1988:83) points out that people tend to view the stoic as mentally sound and morally upright; however, the problem remains that people interacting with individuals who “suffer with dignity” must have some way of finding out about the status of the sufferer’s pain. As already noted, the problem with the stiff-upper-lip approach is that most people find it hard to believe someone is experiencing severe pain unless reminded of it intermittently. Tim Rowe complained that Ben Case, a fellow patient, received a lot of support because his pain “shows on his face and in his walk, his whole mannerism,” whereas when Tim was admitted to CPC someone told him that he did not really look as though he was in pain.

In sum, although keeping a stiff upper lip can inspire respect, it can also inspire disbelief. Why some chronic pain sufferers report finding ways to manage the pain a more serious challenge than the pain itself is, thus, understandable. Pain is doubly paradoxical: It is a quintessentially private experience that depends on social action to make it real to others, yet that very same action can also arouse suspicions about its reality.

Chronic pain and liminality

I can now embark on a more comprehensive examination of liminality, understood to be a consequence of classification systems imposed on the natural world that invariably occlude much of its complexity and gradation. These classification systems allow a society’s members not only to make sense of the myriad stimuli assaulting the five senses but also to be able to judge some as more beautiful or better than others. As this involves highlighting certain attributes of a given phenomenon and ignoring others, boundary-straddling occurs, introducing confusion and potential conflict. Edmund Leach argues that learning a

language involves becoming skilled at imposing on the physical and social environment, originally perceived as a continuum, “a kind of discriminating grid which serves to distinguish the world as being composed of a large number of separate things, each labeled with a name. This world is a representation of our language categories, not vice versa” (1964:34).

Leach continues, “If each individual has to learn to construct his own environment in this way, it is crucially important that the basic discriminations should be clear-cut and unambiguous” (1964:34–35). One contribution to this goal, he hypothesizes, is a process of making taboo those aspects of the physical world that are unnamed in natural languages. Thus, recognition of the “nonthings which fill the interstices” becomes suppressed: “Taboo applies to categories which are anomalous with respect to clear-cut, category oppositions” (Leach 1964:37). To illustrate, Leach points to practices found in many cultures with respect to products and detachable parts of the human body like feces, urine, semen, hair, menstrual blood, and nail clippings. Betwixt and between what is materially “me” and “not-me,” these products are often considered dirty once separated from the body. They are often seen as powerful and serve as prime ingredients of magical potions. Leach also notes that a constellation of attitudes not usually associated with one another accompanies tabooed objects or words: “Whatever is taboo is sacred, valuable, important, powerful, dangerous, untouchable, filthy, unmentionable” (1964:37–38).

In sum, liminal phenomena often elicit high affect of a negative or ambivalent nature. Because, the argument goes, such phenomena do not conform to the logic of people’s understanding of the way their world is constructed, challenging and threatening the “naturalness” of culturally constructed categories, the phenomena may be stigmatized and considered unclean and defiling.

As noted above, in addition to being tabooed, under certain circumstances, especially in ritual, liminal phenomena are highlighted, demarcated, and made into statements—in effect, assigned their own, special categories. Two basic explanations of this categorization process have been offered. A functionalist, social–structural explanation argues that, because liminality reveals gaps and confusions in rules and classifications, emphasizing it in symbol and ritual is a way to appropriate threatening ambiguity to illustrate just how important order and unambiguity are. Max Gluckman (1963) argues that ritual and formal behavior, in general, serve to keep potentially confused, ambiguous, and conflictive social roles distinct by highlighting their differences (see also Babcock 1978).

Psychological functionalist explanations argue that “betwixt-and-between” phenomena disturb one’s sense of order and purpose and that assigning them to their own, special categories relieves anxiety and reestablishes a

sense of order and control.⁴⁴ Douglas (1970) argues that dietary restrictions in the Old Testament classify animals such as pigs, hyraxes, rock badgers, and shellfish as abominations because those species fail to fit the categories set up by a classification system that orders the universe into earth, air, and ocean, with particular kinds of creatures appropriate to each: Two-legged birds fly in the air, scaled fish swim in the ocean, and animals walk, hop, or jump on land. She argues that a concern for order and purity (permitting no mixes, blends, or blemishes) constitutes the overarching theme of Leviticus and that disorder is seen to produce dangerous consequences (Lev. 11:4–5; see also Deut. 14:7).

Kirmayer states that

mind-body dualism is so basic to Western culture that holistic or psychosomatic medical approaches are assimilated to it rather than resulting in any reform of practice. Distress is dichotomized into physical and mental, real and imaginary, accident and moral choice. The duality of mind and body expresses a tension between the unlimited world of thought and the finitude of bodily life. It provides a metaphoric basis of thinking about social responsibility and individual will. [1988:83]

Kirmayer’s analysis of the pervasiveness and tenaciousness of mind–body dualism (and the concomitant requisite normative assessments) brings one closer to understanding why chronic pain is stigmatized because of its liminality.⁴⁵

To begin with, chronic pain mysteriously straddles the mind–body boundary—and the more a pain sufferer lacks a clear-cut diagnosis, the more he or she is ambiguous with respect to this boundary. Kitty Corbett found in her study of a comprehensive pain center that staff resisted the possibility of such boundary straddling; for them, “pain, it seems, was *either* physical *or* mental, biological *or* psycho-social—never both nor something not-quite-either” (Scheper-Hughes and Lock 1987:10).

Also, making the patient accountable for the illness neutralizes the threat to biomedical authority posed by unexplained or uncontrolled sickness.⁴⁶ As Kirmayer states, “Patients are then either rational but morally suspect in choosing to be sick or irrational and thus morally blameless but mentally incompetent” (1988:83).

The treatment program at a center like CPC requires staff to confront some patients by suggesting that they, indeed, are morally suspect or mentally incompetent (see Jackson 2003). Such interventions are seen as necessary because therapy is premised on the assumption that, as body and mind are closely interconnected, achieving insight into the way emotional problems are expressed via the body can result in improvement. CPC’s aim was to get patients to shift to a model of their pain that incorporated

more of an internal locus-of-control explanation (see Bates 1996; see also DeGood and Kiernan 1996) of why their pain persisted, an idea conveyed by many slogans and sayings, for example, "You must accept responsibility for your pain."⁴⁷ Given the staff's awareness of the complex nature of pain and of the stigma attached to psychiatric disorders, such messages were, for the most part, transmitted in indirect ways (except during orchestrated public confrontations, when the messages were quite blunt). Most patients got the message with no difficulty and responded with comments like, "These doctors think you're crazy"; "This pain center says you're malingering"; "That nurse says we wanted to have the pain." Even though some patients' understanding of mind-body integration was often relatively sophisticated and nuanced, the uncertain nature of their problem led many to work hard to demonstrate that their problem was "real," and to adopt a hyper-Cartesian idiom during interactions with health care deliverers, friends, and family. Although pain specialists like Loeser might ask, "Does anyone really believe that a tooth is capable of hurting? Or a back?" (1991b:215), pain sufferers and, for the most part, their primary care physicians continue to see backs and teeth as the location of "real" pain.

Several scholars have explored a "shifty" type of liminality that attaches to people and animals that move around in classificatory space. For example, Leach (1964: 45) hypothesizes that vermin are tabooed and reviled not only because of the damage they inflict but also because they breach territorial boundaries: Foxes and field rats trespass into domestic environs like chicken coops and granaries. Similarly, among the Kaguru of Tanzania baboons represent a confusion between humans and animals because they leave the bush and raid the crops of humans (Beidelman 1973:144–145). Such "out-of-place" behavior on the part of animals sometimes signals a prior "out-of-place" situation involving "a moral disturbance of the ancestral ghosts or God himself" that has been produced by immoral acts of the living, "which in turn lead to a breakdown between the boundaries separating the living from the dead and the world of the bush from the world of humans" (Beidelman 1973:144–145).⁴⁸

Many authors note that such "out-of-place" animals are bad omens. Thai villagers studied by Stanley Tambiah consider the giant house lizard to be one example because it is found in the house but is not a domesticated animal. The monitor lizard elicits a slightly higher degree of opprobrium. A boundary straddler found along the peripheries of both the village and the forest, its flesh is considered poisonous to nursing mothers. But the water monitor, another kind of lizard, is the focus of intense hatred, its appearance ominous, its flesh considered altogether inedible. To call a person a water monitor is one of the worst insults possible (Tambiah 1985:201). Tambiah sug-

gests that this lizard brings forth such revulsion because it is found both on land and in the water, a blatant kind of territorial shifter. Similarly, the vulture, the toad, and the snake do not belong to any major class and "are prone to leave their normal habitat and intrude into the habitat of man" (Tambiah 1985:210). In doing so, they are seen as "performing metonymizing acts that establish unwanted contact with man, thereby bringing bad luck and misfortune. They are negatively valued sacred things that threaten to be out of place and to attack the established order of the universe" (Tambiah 1985:210). Tambiah offers the general proposition that "an unaffiliated animal, if it is seen as capable of leaving its location or habitat and invading a location or habitat of primary value to man will be the focus of strong attitudes expressed in the forms of a food taboo and a bad omen or inauspicious sign" (1985:202).

Chronic pain is liminal in this "shifty," worrying manner because sufferers can move around in classificatory space in several ways. They are often seen to need both medical and psychotherapeutic treatment. Although such an assessment might seem totally unremarkable, as noted above, Corbett found pain clinic evaluators wanting to classify patients categorically as either having physical problems or emotional ones. In addition, a pain sufferer shifts around in morally ambiguous space insofar as his or her entitlement to the help he or she is receiving is contested. Indeed, some of the literature on hypochondriacs, secondary-gain seekers, and malingerers casts them in the role of pests, similar to Leach's vermin, for they invade the territory of others and devour disability payments to which they have no right. Some authors argue that the availability of disability funds only encourages such freeloaders.

Chronic pain sufferers are also "out of place" because of their uncertain status vis-à-vis powerful painkilling medications. The moral stance taken on this issue can range from extreme disapproval of any physician seen to inappropriately withhold relief (the position most frequently encountered in the popular press) to extreme disapproval of any policies seen to facilitate dependency and addiction.⁴⁹ Pain sufferers are "out of place" in this regard because collectively they shift back and forth between regions inhabited by innocent sufferers who are unquestionably entitled to medication and regions inhabited by manipulative drug addicts, liars, and criminals.

Many sufferers of severe chronic pain are also "out of place" temporally, if no one knows whether the painful state will improve, deteriorate, or remain the same. Are these sufferers like initiates in the liminal stage of initiation ceremonies, whose ritualized liminal status is transitory, or more like permanently liminal figures such as individuals with a history of psychiatric inpatient admissions? Turner (1964:97) notes that the liminality pertaining to

states that have been ambiguously or contradictorily defined differs from the liminality characterizing ritualized transitions between states. Here, as in other ways, the status of many chronic pain sufferers cannot be nailed down: They are “not-quite-either” or “some of both.”

Some CPC patients’ frustration over their condition was sometimes less the result of pain’s invisibility per se than of the ontological uncertainty of its reality. Some spoke of longing for missing limbs, diseases like cancer, and therapeutic devices like pacemakers that, although hidden, would instantiate an ill body in a way that complaints of pain and reluctance to engage in certain activities did not. Such “real” signs of an abnormality speak in the Cartesian idiom of objectifiable reality that can be socially apprehended and can, therefore, furnish the common ground of patients’ interactions with those whose incomprehension of patients’ state and unwillingness to grant it full legitimacy results in such high levels of frustration. Missing legs, cancer, and pacemakers would provide a pass out of this ontologically liminal space and into one in which patients’ condition, and their selves, are more legitimate.

In sum, as a collectivity, chronic pain sufferers not only straddle several boundaries but they also wander from category to category in a “shifty” manner. They threaten the logic of the classification system by straddling the mind–body boundary and revealing its inadequacies, and they threaten the ethical and normative implications accompanying that system by defying attempts to classify them as a particular kind of moral being. They embody disorder: As Eccleston and colleagues, paraphrasing William Ray Arney and Bernard J. Bergen (1983), state, “Pain can only make sense for those directly involved in it as an index of disequilibrium. Such disequilibrium and disorder are threatening to both patient and physician. This is a disorder which invites and demands resolution,” but, they note, attempts to stabilize the disequilibrium only “provide opportunities for repeated failure” (1997:707).

Chronic pain sufferers share with the physically disabled (many of whom, of course, suffer chronic pain) a marginality caused by possession of imperfect bodies.⁵⁰ The physically disabled are indeed stigmatized; they have been “reduced in our minds from a whole and usual person to a tainted, discounted one” (Goffman 1963:3). Society views them as less than normal and only problematically entitled to the sick role. That many disabled people challenge such societal expectations and values doubtlessly influences, but does not eliminate, such attitudes. But chronic pain sufferers also occupy another kind of liminal space, for their problem relates in complicated and poorly understood ways to mind–body borderlands. In biomedicine, the mind is itself liminal; the entire mind can be spoken of as a liminal state. With respect to “the unlimited world of thought and the finitude of bodily

life” (Kirmayer 1988:83), biomedicine is unmistakably clear that the only good state is the physical state. Sullivan goes so far as to argue that speaking of “Cartesian dualism” is incorrect, for René Descartes arrived “at a full-fledged ontological dualism which opposes mental and physical substance absolutely . . . [whereas] modern medicine refuses to acknowledge anything like a separate or separable mental substance” (1986:343, 344). Although the articulation between chronic pain and disability status is complex and dynamic, clearly, chronic pain sufferers see the processes that stigmatize them to involve their mind.⁵¹ Saying “I’d rather have cancer, I really would” recognizes and signals their dissatisfaction with this double liminality.

As Leach (1964) points out in his discussion of the verbal abuse that appropriates certain animal names (as “bitch,” “swine,” and “goat”), some animals are more liminal than others. Chronic pain sufferers resemble those animals that display more than one liminality, creatures that offer the most blatant challenge to a given system of classification.⁵² By applying scholars’ analyses of why certain creatures are seen to be so anomalous that their irregular nature and behavior are “not merely puzzling but even offensive to the dignity of human reason” (Douglas 1967:236–237), one can see how chronic pain sufferers might also come to be perceived as a kind of classificatory and moral “monstrosity.”⁵³

Conclusions

Even though pain itself is invisible and, unlike many other kinds of marks, does not automatically elicit feelings of disgust or revulsion, most sufferers of severe chronic pain say they feel stigmatized. This article has examined the degree to which some of the work on stigmatization in sociology, social psychology, and anthropology can promote understanding of the stigma experienced by such sufferers. I have suggested that models developed in so-called exotic societies can help in analyzing the several ways that pain sufferers exhibit liminal qualities and inhabit liminal space, revealing part of the cultural logic of biomedicine. One source of stigmatization derives from Parsons’s point that the sick role offers only conditional, time-constrained legitimacy, which results in all chronically ill persons being relegated to a semilegitimate status. In addition, that chronic pain sufferers are neither properly well nor properly sick puts them betwixt and between the statuses of sick and well. But the most important sources of liminality are the result of certain conceptual and moral foundations of biomedicine that classify people into categories that pain sufferers often straddle, including those based on two of biomedicine’s most basic discourses. The first discourse, illustrated by the imputation of psychogenic pain, is that of the real and unreal—Kirmayer’s “physical and mental, real and imaginary”

(1988:83). The second—Kirmayer's "accident and moral choice" (1988:83)—is that of responsibility.

If, as Kirmayer suggests, the dualism of Western culture is firmly rooted in the West's construction of the moral order and the person, then understanding the role played by "the fundamental experiences of agency and accident, and their moral consequences" is crucial (1988:58).⁵⁴ I have suggested that pain sufferers occupy an ambiguous space with respect to agency, as opposed to completely involuntary, action and that, as a consequence, any moral evaluations concerned with agency will also be ambiguous. Such ambiguity turns sufferers into quintessentially liminal figures, vulnerable to the stigmatization such figures so often provoke because the sufferer transgresses several crucial boundaries that people find essential for understanding, ordering, and evaluating experience. I have argued that chronic pain sufferers are seen to attack the established order of the part of the universe having to do with received wisdom about the body and mind. Chronic pain stigmatization illustrates certain pervasive processes that occur in all societies, processes that separate, demarcate, purify, and punish.

Despite good intentions, health care professionals can significantly contribute to the sense of demoralization experienced by chronic pain sufferers, in part because certain therapeutic philosophies require that pain sufferers be made deeply aware of the connections between the mind and body.

Pain centers continue to diagnose patients and conceptualize pain in quite diverse ways. These disparate regimes of truth mean that both pain patients and pain clinicians, during the mid-1980s and up to the present, have found their object of analysis to possess an "excruciatingly ambiguous" nature (Csordas and Clark 1992:391). That pain medicine, rather than being a unified field, lacks consensus on crucial diagnostic criteria results in interactions between practitioners and pain patients that can lead to feelings of failure, ambiguity, and frustration because such interactions instantiate the "fundamental medical anomaly" that pain represents at present. Despite the paradigm shift that has occurred in pain medicine with the widespread acceptance of a unified model, Melzack and Wall's gate-control theory, pain continues to occupy liminal space.

Although stigmatization of the chronic pain sufferer in part results from social labeling and social-control processes, perhaps a more elusive source is also present, one reflecting that people suffering some forms of chronic pain find themselves in a kind of no-man's land between the real and the imaginary, and between innocence and irresponsibility—up to and including criminality. Their condition requires them to deal with the consequences of inhabiting a space that is both mental and physical and both guilty and innocent. Biopsychosocial therapies that

talk of managing pain, rather than curing it, assign far less responsibility to the health professional, who, in Shelley E. Taylor's (1995:594) words, is "co-managing the problem with the patient. If the new technologies are to work, patients must consent and actively participate" (Kugelmann 1997:59). Being "responsible for one's pain" requires disciplining the body and mind. The goal is to transform the passive patient into, as Fordyce phrases it, "a subjective agentic" patient—someone who "must cooperate" in a process of rehabilitation (Eccleston et al. 1997:707). Ruthbeth Finerman and Linda A. Bennett argue that the new "responsibility and blame focused" explanatory models "have the added consequence of stigmatizing and further victimizing victims by ascribing blame . . . [such that] disease, onset and outcome are directly ascribed to the afflicted themselves [who] are then subject to censure for personal failures which 'caused' their condition" (1995:1). "Such patients are forced to fight both health threats and social stigma or sickness-induced 'shame'" (Finerman and Bennett 1995:2). As Eccleston and colleagues note, pain professionals' repositioning of themselves from a "healer" role to a "manager" role "has been recognised as a common response of orthodox knowledge when faced with threat and challenge" (1997:707); and, "in chronic pain, when the cause remains lost, the patient reappears to own that loss: the patient becomes the lost cause" (1997:700). Arney and Bergen (1983:1) speak of the behavioral medical gaze extending to the most intimate aspects of life. Kugelmann considers such an implicit "morality of responsibility" in pain management to be "deeply exploitative" (1997:59) and complains that "what are no longer recognized in the biopsychosocial chart of existence are limits. There are no limits to intervention into the patient's life" (1997:62).

The degree to which changes in the biomedical paradigm, in particular, its shift to ever greater acknowledgment and incorporation of mind-body connections, will benefit sufferers of chronic pain, by constituting less anomalous categories for unwell persons like themselves, is anyone's guess. Many indications that such a shift is occurring can be found: Current work on placebo is one example (see Ader 1997; Hahn and Kleinman 1983; Harrington 1997; Moerman 2003), current work on psychoneuroimmunology another, and, of course, recent work on the neurology of pain (see, e.g., Hardcastle 1999; Melzack 1996) is a third. Fields, a neuroscientist, says that recent research has "brought the most clinically relevant aspects of pain out of the realm of pure psychology and into the realm of neuroscience. A corollary of this [has been] to provide enhanced respectability for pain patients, for the physicians who cared for them and for the scientists working in the field. Instead of asking, 'what's wrong with this person?' the question became, 'what's wrong with their nervous system?'" (in press). The focus is still on

“the person,” rather than on tissue damage or malfunctioning organs, but the nature of the person has been significantly revised. If this shift transpires, the implications for the moral dimension are clear—as implied by Fields’s use of the phrase “enhanced respectability.”

Pain research, both clinical and experimental, mounts challenges to specific “tenacious assumptions” of biomedicine (see Gordon 1988). Perhaps in several years’ time sufferers of intractable chronic pain will be the targets of less opprobrium because their status as classificatory and moral “monstrosity” will have significantly decreased. Researchers like Fields seem to be optimistic about the potential for new discoveries to eliminate mind–body dualism once and for all and to ease stigma. Other scholars are not so sanguine.

Notes

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1. *Biomedicine* refers here to the foundational philosophy of Western medicine. According to Arthur Kleinman, the biomedical model refigures disease as an alteration in biological structure or functioning. “Biomedicine presses the practitioner to construct *disease*, disordered biological processes, as the object of study and treatment” (Kleinman 1995:31). The physician’s task is to replace the patient’s complaints, regarded as subjective self-reports, which are necessarily biased observations, with objective data. Such data, based on verified and verifiable measurements, allow the doctor “to decode the untrustworthy story of illness as experience for the evidence of that which is considered authentic, *disease as biological pathology*” (Kleinman 1995:32–33). The literature on this issue is vast; see, for instance, Kirmayer 1988 and Schepher-Hughes and Lock 1987. Medical practice—actual health professionals treating health-seeking individuals—of course, reveals many departures from its biomedical foundational base.

2. This article deals only with embodied, consciously experienced pain.

3. For example, many authors attempt to distinguish between pain and suffering; Eric Cassell’s popular definition sees pain as “a specific state of distress that occurs when the intactness or integrity of the person is disrupted” (1999:531). Yet, as John D. Loeser (1991b:216) points out, the language of pain is used for all types of suffering.

4. See also Robert Murphy’s (1987) characterization of himself as occupying liminal space while he coped with a slow-growing benign tumor that resulted in increasing disability.

5. Other anthropological work includes that of Audrey Shalinsky and Anthony Glascock (1988), who rather mechanically impose a liminal framework on their analysis of killing infants and the aged in nonindustrialized societies. Robert Hayden (2000) employs the concept in his interesting analysis of sites of ethnonational conflict characterized by mass rape and of sites where rape is not used as a weapon. Phillips Stevens (1991) profitably returns to van Gennep’s liminalities in his discussion of rites of passage in West Africa. And Sharon R. Kaufman (2000) presents a fascinating treatment of the liminal in her article on how a “persistent vegetative state” destabilizes the existing social order in unique ways.

6. This is not to say that views other than negative ones, for example, sympathy, do not occur.

7. Nociception is a noxious stimulus that results in pain.

8. Further discussion of etiologic and treatment models can be found in Baszanger 1998, Bates 1996, Hardcastle 1999, Priel et al. 1991, and Vrancken 1989.

9. See, for instance, Bendelow and Williams 1995:143, Corbett 1986, Eccleston et al. 1997:700, and Lennon et al. 1989. Also see Finerman and Bennett 1995 for a more general overview.

10. The actual relationship between nociception and pain is far more complicated; for example, central nervous system pain states are characterized by pain without peripheral tissue damage (Loeser 1991b:215–216).

11. That pain medicine is a multimillion dollar business is one element contributing to the intensity of debate.

12. See, for instance, Loeser 1991b, Sullivan 2001:147–149, and Turk and Rudy 1992:100.

13. Gamsa also critiques methodology, noting selection biases, overinterpretation of correlational data, inappropriate use of tests, biased interpretation of data, distorted logic, errors of inference, and selective interpretation.

14. Mark Sullivan notes that the rest of medicine has not accepted this meaning of “chronic pain,” preferring “somatization . . . because it permits explanation of symptoms in terms of defects within the individual—as the clinicopathological method demands” (1998:200).

15. See Engel 1959 and Merskey 1984:64, 2004; cf. Roy 1985.

16. See, for example, Merskey 1987. David Swanson (1984), among others, sees chronic pain as the “third pathological emotion” (along with depression and anxiety).

17. These conditions include phantom limb pain; see Melzack 1989. Also see Gamsa 1994:22.

18. See, for example, Merskey 1984.

19. He notes that “about 80% of healthy individuals experience somatic symptoms in any one week . . . psychological problems affect up to 30% of patients presenting to physicians in general practice, often with physical symptoms initially . . . of which the most common is almost always pain” (Merskey 2004:70). He cites a study of family medicine clinics in which 26.3 percent of patients met the criteria for one or more of the forms of somatization.

20. Merskey continues: “For this category [persistent somatoform disorder], it is important to make such a diagnosis only on the basis of substantial psychological evidence. The exclusion of organic disorders is not sufficient to warrant the diagnosis [pain disorder], and there must be positive evidence so that *if the criteria are followed carefully, this diagnosis will rarely be made*” (2004:70). Merskey had, in fact, criticized facile diagnosing earlier: “The doctor should also be sure to establish that there is definite psychiatric evidence for the pain. If he cannot find such evidence he should not accept the patient as having a psychiatric problem” (1984:66).

21. For example, in a review of the literature, Roy 1985 finds no association between child abuse and pain proneness.

22. See Turk and Flor 1987:279–280.

23. See Kleinman 1988:172–182, 1992 for critiques of such approaches.

24. Merskey's comment on the debate between psychodynamic adherents and operant-conditioning adherents wins the prize for understatement: "What this all amounts to has been a topic of some controversy" (1984:65).

25. See, for example, Keefe et al. 2001.

26. Genest agrees: "'Pain' means an aversive or distressing perception. To speak of pain without anguish—*affectless pain*—is to stop speaking about pain" (1985:60). Sullivan argues that emotion is "part of the pain experience itself . . . if pain is not aversive, if it does not include a clearly negative affect, it is not recognizable as pain. Neither the location nor the sensory qualities of pain make it compelling and unique. Pain's aversiveness makes it unique" (1996:208; see also Sullivan 2001:152).

27. "The purely discriminative part . . . includes recognizing the quality of the sensation as a burn and localizing it to your hand. Second, there is the motivational aspect associated with the desire to pull your hand away or to terminate the sensation. Third, there is an evaluative component; the thought of the damage that has been done to your hand" (Fields in press). See Melzack 1985 on "parallel processing systems" and Damasio 1999:293–294. Note that Sullivan critiques the argument made by pain psychologists like Melzack "that sensory and affective aspects of pain are processed conjointly rather than consecutively" (1995:12) because their parallel processing notion fails to interrogate the basic event-interpretation model.

28. This point is, indeed, counterintuitive; CPC patients made a clear distinction between emotional and physical pain, although they were talking about cause rather than experience. Kugelmann, who studied chronic pain patients' talk in encounter groups, puts it this way: "Because the participants had no definitive medical explanation for their pain, they had no legitimated account which would have resolved the ambiguity between physical and emotional pain—or shall we say obscured the ambiguity?" (1999:1667). In another publication he notes that "psychological and physical pains are ambiguous as to whether they are ways the narrators found themselves attending to the pain or they are the pains to which they were attending" (Kugelmann 2000:308; see also Kugelmann 2003). Bryan S. Turner addresses this issue, as well:

If we recognise pain as an emotional state, then we immediately begin considering the idea of the person as an embodied agent with strong affective, emotional and social responses to the state of being in pain . . . the main point of this example is to draw attention to a neglected aspect of the sociology of health and illness for which a theory of embodiment is an essential prerequisite for understanding pain as an emotion within a social context. [1992:169]

Following a discussion of Turner's point, Bendelow and Williams comment that

Yet one of the central paradoxes of pain is that whilst at a philosophical level it may demand the dissolution of such dualistic thinking, at the phenomenological level of experience they may be re-erected, as pain, in its negative mode, can serve to alienate or estrange us from, and thus "objectify" our bodies. Hence a phenomenological investigation of pain should be alive to these contradictions and the paradoxical nature of pain as an embodied experience. [1995:160–161]

They suggest that asking searching questions "about the role of emotions, both to those suffering from pain, and the professionals who treat them" (Bendelow and Williams 1995:160–161) may lessen the degree to which patients diagnosed with "psychogenic" pain are stigmatized. Greenhalgh 2001 also discusses the issue of the role of emotions in patient–clinician interactions (see also Jackson 2002).

29. Note that some centers treat only one kind of problem, such as lower-back pain or headaches, and the etiology and diagnostic status of some painful conditions (e.g., fibromyalgia) are still in dispute.

30. By 1987, according to the U.S. Department of Health and Human Services, there were 1,500 pain-treatment facilities in the United States alone (Kugelmann 1997:56).

Csordas and Clark, discussing research carried out in the 1980s, noted that most pain centers concentrated neither on a particular type of illness nor a particular organ system, leading them to worry about chronic pain being isolated within an "ontological shell" (1992:392). They also worried that the diagnosis "chronic pain syndrome" reified what, in fact, was a complex range of conditions (Csordas and Clark 1992:389; see also Kotarba 1981).

31. *Chronic pain syndrome*, a diagnostic term for chronic pain of unknown origin, was used in many pain-treatment centers during the time of my research; see Jackson 2000:6.

32. See Rich 2002; see also Grahmann et al. 2004, Haddox and Aronoff 1998, and Lipman 2004.

33. For examples, see Finerman and Bennett 1995, Jackson 2005, Kleinman 1992:170, Kotarba and Seidel 1984:1394, Porter 1994:107, and Sullivan and Loeser 1992:1830.

34. See Kalb 2003. An ad for a pain-management video gives the figure of 86 million (Aquarius Health Care Videos 2003).

35. See, for instance, Ablon 1981, Crocker and Major 1989, Goffman 1963, and Jones et al. 1984. The literature on this subject is vast; Crocker et al. 1998 provides an extended social psychological bibliography and Link and Phelan 2001 a comprehensive assessment of the field from a sociological point of view. For a critique of the theory's usefulness for cross-cultural research, see Good and Good 1994 and Kleinman et al. 1995:1320, 1328. The copious literature on stigma is ably discussed and critiqued by Link and Phelan.

36. Kotarba and Seidel 1984:1399 provides a chronic-pain example. See Lennon et al. 1989:120 for more examples of labeling involving chronic pain and Crocker and Major 1989 for a discussion of self-fulfilling prophecies. Farina 1982 discusses social psychology experiments in which subjects' belief that they were viewed as stigmatized influenced their behavior in such a way that other people with whom they were interacting in the experiment rejected them: "The study suggests not only that social attitudes and beliefs about stigmas influence the behavior of the stigmatized, but also that the social rejection blemished people encounter is, in part, caused by themselves" (1982:346). "Very different kinds of socially degrading conditions . . . appear to have an effect on the possessor merely as a result of his thinking others have become aware of it" (Farina 1982:347). Although Farina does not cite the work, this is what the classic labeling theory hypothesizes (e.g., Becker 1963). On the powerful effects "felt stigma" (the fear of meeting with rejection) can have, see Graham Scrambler and Anthony Hopkins's (1990) analysis of epileptic stigma.

37. Other references dealing with stigma and chronic pain include Bates 1996, Kleinman 1988:158–169, and Lipton and Marbach 1984.

38. All patient names are pseudonyms.

39. This does not mean that individuals who see their pain as organic do not recognize overlays of what can be called "emotional" pain.

40. See Susan Sontag's (1977) discussion of stigmatization of

cancer sufferers resulting from their perceived blameworthiness for having personalities predisposed to develop the disease.

41. Keefe and Dunsmore 1992 discusses clinicians who, on realizing that pain behavior such as guarded movements or facial expressions are conscious efforts, become upset and even “enraged” (Sullivan 1995:11).

42. Norma Ware (1992:354), discussing the shame some persons suffering from chronic-fatigue syndrome experience, notes that some of these people also say they would prefer to have cancer.

43. Cademenos 1981 reports one patient as saying that he wished he could wear a badge that said “Chronic Pain.”

44. Also see Crocker 1973 and Morris 1987 for discussions of various social, cognitive, and affective-emotional theories explaining why, under certain circumstances, liminality is highlighted and exaggerated.

45. Also see Gordon 1988 and Young 1980.

46. Eccleston et al. discuss ways in which accounts by both pain patients and clinicians resist blame or deflect it away from individual ownership: “When pain is no longer useful as a symptom, identity is challenged, weakened and at risk for both chronic pain patients and pain professionals” (1997:699). Patients are stigmatized as “difficult” and uncooperative, as “imagining” the pain, suffering from a psychosomatic illness, or “seeking attention”; the patient sees the clinician as incompetent or uncaring (Eccleston et al. 1997:700).

47. Sullivan and Loeser speak of “the fine line of not holding the patient responsible for his illness but of clearly holding him responsible for his recovery” (1992:1830).

48. Note that not all liminal animals are viewed negatively. See Beidelman 1973, Douglas 1967, and Leach 1964 on anomalous animals as mediators—the pangolin in Africa being the quintessential example (“a classic object of confusion and thus potency” [Beidelman 1973:146; see also Beidelman 1986:97–101]).

49. See, for example, Kolata 1994 and Rosenthal 1994. Melinda Henneberger (1994: 3) quotes Dr. Herbert D. Kleber, an expert on addiction and substance abuse, as saying that Americans see people who need medication as weak.

50. Of course, the chronic-pain population and the disabled population overlap in several significant ways. I am constructing ideal types of the two as a heuristic for explicating this point.

51. The identity of pain sufferers may also be shifted from that of a person in pain to “a pain person” (Eccleston et al. 1997:707). See Sue E. Estroff’s discussions of the differences between “I have” conditions (e.g., AIDS, lupus, cancer) and “I am” conditions (e.g., alcoholism, diabetes, epilepsy): “‘I am’ illnesses are more mysterious and more stigmatized, entail more disruptive, disapproved expression, and are most likely to be centered in the brain or to involve cognitive function. They are also more offensive to moral convention regarding individual restraint and responsibility” (1993:257). Attributions of blame for “I am” conditions tend to rest with the individual.

52. See Tambiah 1985:210; see also Bulmer 1967.

53. Douglas provides a telling example of a 17th-century French grammarian confronted with a female whale suckling her young in the mid-Atlantic; he is appalled and revolted: “One is disgusted, one does not know where to put one’s eyes” (1967:236–237).

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