

Mini Review

Pain and culture - on cultural communications of suffering

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Abstract

The impact of culture on the communication of pain becomes visible in a comparative perspective when individuals with two different cultures meet.

Regardless of the physiological cause, it is through lived experience, in social life, that it is decided how, where, when and for whom pain is to be communicated. Age and gender, situation and context as well as the type of pain are essential ingredients in communication. The communication is always adapted to expectations from those present, their own experiences of pain and the specific circumstances, the cause of the pain. The impact of culture on the communication of pain becomes visible in a comparative perspective when individuals with two different cultures meet.

The comparative perspective of pain

A small boy is out playing with his bicycle. When he is quite far away from home he falls and hurts his leg. He shows no sign of pain but takes his bicycle and walks all the way back home. When seeing his mother he starts to cry. While his mother tries to console him, by using the symbolic ritual of 'blowing' on the wound to make the pain vanish, she asks her son how it all happened. The boy cannot tell her since he had been too far away from home, where he was not supposed to be alone. He feels thus responsible for his pain.

In another context, a small boy is being circumscribed. An elderly healer removes the foreskin of the boy's penis with his knife. The boy is surrounded by his family and most of the members of the small village while going through the ritual. Blood is pouring from the cuts but the boy shows no signs of pain. He is given gifts and the whole village celebrates.

Regardless of the physiological cause, it is through lived experience, in social life, that it is decided how, where, when and for whom pain is to be communicated. Age and gender, situation and context as well as the type of pain are essential ingredients in communication. The communication is always adapted to expectations from those present, their own experiences of pain and the specific circumstances, the cause of the pain.

It would have been impossible for a person with no insight into the culture of the small boy with the bicycle to have 'seen'

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that he was in pain before he met his mother. The boy has learned that boys should not cry and they should not show feelings in front of strangers. These cultural norms together with his feelings of guilt from playing at a forbidden place mean that the boy does not show his pain until it is relevant from his point of view.

The other example is also totally incomprehensible without cultural competence. How is it possible to understand the acceptance of such phenomena as the introduction of pain in ritual processes such as circumcision, scarification, burning and other such rites? When doing fieldwork in Middle Anatolia among Muslim families I was present at a few such rituals. I was taken by the stoicism of the young boys when seeing them in a situation that must have been quite painful. But when I got more insights into the impact of the importance of the initiation to the grownup world that the boy had been prepared for during his entire childhood, the behavior became more comprehensible. Transition rituals, in this case from a boy to a man, thus show quite clearly how the communication of pain is formed in experiences and culture that people share.

The impact of culture on the communication of pain becomes visible in a comparative perspective when individuals with two different cultures meet. During my fieldwork among Turkish families, I had the opportunity to experience a couple of women during their first pregnancies in Sweden. One of them had six children before that she had given birth to in her home in the Anatolian village. In Sweden, she was surveilled



during her pregnancy, as every other woman and when the time came that she should give birth to her child, I went with her. The following description is from my book *Evil Eye or Bacteria* [1]:

'While her contractions were still quite weak the healthcare staff left the room, telling the woman to press a button when she needed help. She wandered about the room, moaning quietly, interrupted only by the entry of a nurse or midwife, who got her up onto the bunk every time so that they could listen and look at her, feel her pulse and so on. When the contractions became so strong that the woman was not able to get down from the bunk, she sat on it and started to moan louder and louder with a monotonous rhythm. This brought three people into the room to find out what the matter was. They tried to quiet the woman by telling her to 'do her best' and not to scare the women in adjoining rooms. The woman was then oblivious to her surroundings; she had embarked on a process that only she could cope with. Everything she did seemed self-evident and composed, though rather audible.

The midwife fetched a doctor and they held a muted discussion, heads close together, at the foot of the bunk. A little later the midwife administered an injection to the woman, who was now in the throes of labor.

After some minutes her moans gave way to tears and she sobbed that her child had died. She felt nothing, no pain, everything had stopped and the baby was dead. When the midwife realized that she thought something was wrong, she explained that a pain-killing injection had been given and that everything would now be calmer and better for her, not so painful. This made no impression on the woman who continues to cry and repeated over and over again that the baby had died.

The birth was however over in half an hour but the woman was indignant that it had taken so long after all. It was usually so easy; one walks around until the time comes and then just squats. She had never had such a troublesome delivery.'

How biological pain like labor pain is perceived and reacted upon varies. Some women are used to giving birth in pain as a positive indication that the process is as it should be. In the Western world pain in relation to labor has more and more been directed towards an ideal of relief from pain. Some women in the West even prefer a caesarian cut to avoid labor pains.

Questions relating to pain and culture are complex no matter how they are approached. For an anthropologist the best way to deal with pain and other types of suffering is in a comparative perspective; as culturally created and communicated. Other societies and other cultures are 'good to think with and to make well-known interpretations of pain just as 'exotic' as every other effort to understand and deal with it.

But how is culture defined if used as an overall concept where pain and suffering is created, interpreted and changed? In anthropology, there are a number of definitions of culture, let alone all definitions in other disciplines. For my purpose here I define culture as the socially created consciousness that is made available and transmitted through the communication between members of a society or social group. Culture is thus not static but may be transformed and changed over time through interaction and communication.

How can pain be defined? Pain could of course be defined as an experience from the body, an experience that is communicated in a culturally self-evident and prescribed way to be visible to others. For the anthropologist, it is necessary to study pain as a verbal or non-verbal communicative act in context. The interpretation of the language of pain is usually made through ethnographic studies.

The anthropology of suffering

Moving from the examples of pain in accidents, rituals and birth there is a discussion going on among anthropologists today dealing with the causal aspects of pain and suffering as a whole. Within the framework of *The Anthropology of Suffering* [2] an effort is thus made to deal with the social grounds of suffering and the cultural representations of pain. In the overall discussion, there is a view that 'the work of society is to transform human misery into suffering and to counter pain with healing [3]. Society, including the culture of health care and medicine, is seen to transform various kinds of misery into suffering, into symptoms that may be classified under such headings as depression or chronic pain, thus allowing them to be dealt with by appropriate forms of medical practice. According to the perspective of *Critical Anthropology* [4] in prioritizing advanced medical technology, there is a risk of allowing the structural causes of misery and suffering to persist.

In my experiences as a member of the board of the Center for Tortured Refugees at the Red Cross in Stockholm, I got several opportunities to revise my cultural interpretations of what pain was all about for various individuals at the Center. When listening to narratives about torture the Swedish team of clinical experts was taking steps to create therapeutic means for the suffering persons. Labels and diagnoses like Post Traumatic Stress, (PTS), made the incomprehensible descriptions possible to handle. When the tortured refugees entered the therapy they became victimized and dealt with as 'patients'. As a couple of the refugees refused to relate to the therapy there was confusion among the staff who were working hard to help them cope with their memories and normalize their lives. It became obvious that some of those who had been treated in the bestial way by their torturers felt pride as the torture proved that they had struggled for the right cause. 'Blowing on the wound' was not the right type of therapy for some of these men and women. They were rather in a situation of transition where they were heroes through



what they had gone through. The anticlimax and frustration that the tortured refugees experienced may have as much to do with not being seen as heroes for their political and social struggle as they became victimized and medicalized as patients.

From an anthropological point of view, biomedicine is part of society and thus culturally created and changed over time depending on social, political and economical factors. It is in the interactions between biomedicine and other culturally created ways of dealing with suffering that I have had an interest in over the years.

The causes of pain

A feature common to all cultures is that when a serious threat to human life is encountered, normal rhythms of daily life are disrupted and questions are provoked in an effort to create order from disorder [5].

The belief in invisible phenomena like magic and witchcraft help people create such order just as some of the biomedical beliefs in bacteria and virus or injuries in DNA help others to do so. Causality helps people deal with various types of suffering. Some look for causes mainly inside the body while people who do not share natural science or biomedical understanding look for causes mainly outside the body.

In the tradition of Hippocrates, the biomedically oriented practitioners begin a process of diagnosing causality by asking questions about the whole (not meaning a holistic whole however where social references are made) and then moving toward a concentration on the parts. Is the patient in pain suffering from a disease of the body or the mind? What part of the body or mind? Which organs, and in turn which parts of organs are causing the pain? As the figure indicates, this line of questioning reaches even the molecular level today, as specialists try to learn about smaller and smaller parts of the human body to be able to diagnose a present state but also a possible state in the future [6,7]. In contrast, other diagnostic models tend to view a problem from a holistic perspective where social references are made. An individual is never seen in isolation but is always seen as part of society. Pain and illness are perceived as being caused by a disruption in a person's relationships within the social domain, particularly with living relatives but also with the spirits of the deceased kin. This approach tends to address the question 'of why' one is in pain, whereas the biomedical approach has traditionally focused on the question 'of how' pain has come about. In the following, I hope to be able to mirror these two views.

Pain with or without medical 'proof'

As causality is so important for striving to stay healthy it also has an impact on preventive health care and surveillance medicine in our modern world. Suffering usually triggers intervention and the surge for causality. There is also pathology without suffering that can be visualized. As a consequence of

my interest in health communication, I have concentrated my research on these two extremes where particular problems can be found in the interaction between doctors and patients today. I want to define these situations.

Illness comprises expressions for the subjective perceptions (symptoms) which are not necessarily visible (pain) but are communicated, verbally or otherwise, in a culturally prescribed manner. Disease on the other hand is a state of ill health (not necessarily perceived) objectively observable as pathology, mainly through medical technology and classified, explained and often possible to treat with biomedical means. Where illness and disease overlap there is a clear mandate for health care. But where they do not overlap there is another type of problem related mainly to the communication of feelings on the one hand or of pathological findings on the other.

Focussing on illness without disease there is a whole range of ailments where no pathology can be found. The diagnostic dilemma posed by chronic pain without any demonstrable evidence of serious physical disorders or pathology is being studied and discussed among medical and social scholars alike. Some of the issues have to do with whether a diagnosis based on symptoms, such as for example chronic fatigue syndrome, is disabling because the label prompts people to identify with the diagnosis. At times both physicians and patients seem to be uneasy about the possibility of a self-fulfilling prophecy that might have deleterious consequences [8]. The authors note that the diagnosis also has an enabling aspect, in that people in search of a name for and some kind of confirmation of their suffering are reassured in their relations with the surrounding world. To suffer for many years, with no explanation for one's problems and no understanding of a serious complaint of pain and fatigue, may impede recovery. A diagnosis, in this case mainly a label, can contribute to the identification of a legitimate sick role at least in a world where one is depending on biomedical confirmation.

The communication of pain

Given that man is a social being, serious consideration is due to what social relations - interactions between people in daily life - have to do with pain and sickness. Such interactions ought therefore to be included in etiological descriptions and interpretations, especially where there is a pain but no pathology.

In descriptions of women and men in Mexico, the anthropologist Kaja Finkler [9] gives examples of how the quality of 'anger' leads to pain. Anger is made when tacitly accepted ideologies are violated, as when women, conceding to the prevailing standards of male dominance and female submission, fail to realize the rewards of submission, as when the spouse spurns them. Anger is made when neighbors harass one's children. One woman who is part of the study, suffered from constant pain (ibid:37-38). She lived on top of



a garbage heap in a house constructed of tin and cardboard. She attributed her perpetual pains in the head to lack of food but mainly and foremost to the anger resulting from conflicts she was having with her neighbors. For her, as for many other women in this area, inimical social interactions and their moral underpinnings took precedence over miserable physical surroundings and living conditions in provoking her anger. These women argued that the way to be cured of the resulting pain was only by means of less anger or relief.

The merge of the 'how' and 'why' of pain

Chronic pain poses a dilemma in that biomedically trained practitioners are searching for disease while patients are initially more prone to discuss their sufferings in terms of their total life situation [10]. Both views can be understood as culturally constructed modes of interpretation that shape perception, interpretation, labeling, and help-seeking. As regards chronic pain, research and practice attach great importance to somatic dysfunction. The general approach has given rise to a reliable culture-specific system for the classification of medical diseases. In chronic pain, the causality as described from the patient's point of view includes the life situation as well as bodily dysfunction. The diagnosis, on the other hand, derives from the bodily symptoms, not from the patient's version of causality. It is, moreover, often an absence of findings within the body in pain that may underpin the diagnosis [11].

This means that words, a language, have to be found whereby people can communicate inner sensations to others that do not have access to those sensations. Metaphors and body language may be used to convey that which is invisible to others. There is a notion of chronic pain as pre-objective; pain may be in a stage where a subject-object distinction has not yet occurred [12]. Such a discussion also explores relationships between pain and language. Pain, like chronic suffering in general, might be construed as pre-linguistic.

When medical questions are put concerning physiological, mechanical, chemical, pathological, or other causes, the sensation can be elaborated linguistically. In some cases, however, sufferers of chronic pain complain about the way pain "resists objectification" [12]. A situation in which patients with chronic pain may be assisted in the objectification of their sufferings is biomedical consultation. In such a situation, patients in our part of the world are led to believe that the intrinsic meaning of their pain resides in a medical cause.

The examples above of biological pain, pain in accidents, rituals, and torture may help us reflect on how culture inevitably makes interpretations ethnocentric and therefore irrelevant. A medical diagnosis of pain may fail to interpret the cause of suffering since biomedicine in its surge for a treatable disorder lacks cultural competence in the world of the patient.

A considerable body of research in a wide range of disciplines has shown that social factors are generally capable

of influencing the onset and development of certain diseases as well as people's life expectancy and general well-being. Research in medical anthropology indicates how illness is conditioned by the body's interaction with society. Studies of the social origins and development of neurasthenia (regarded as a predecessor of chronic fatigue syndrome) in China reveal that the Cultural Revolution, together with certain basic principles of Chinese culture, is mirrored in the constellation of symptoms and illuminate their meaning [13]. Studies of chronic fatigue syndrome in the United States and in Sweden aim to find some common factors among the patients [10,11,14-18]. Attempts to derive the cause of these patients' great suffering from events in their life history also raise the issue of how experience is expressed and presented.

Connections have been found between the ways in which symptoms are described in the individual's immediate surroundings and the social forces in a broader context. Ongoing dialectical discourses of this type between society's micro and macro levels also illustrate suffering's social implications and show that social processes may be involved in the occurrence and development of chronic illness [19-21]. In this way, the symptoms can express embodied experience and cultural sources of suffering, which raises the issue of how society, culture, our bodies, and our lives are interwoven so as to generate pain and suffering.

Conclusion

There are a few fruitful examples of holistic approaches where people in pain are treated as though they are whole social beings with experiences and history, ingredients that have an impact on their suffering. What comes out as a synthesis and in fact, one of my primary concerns is the possibility of liberating medical research and practice from its Cartesian heritage, the duality of mind and body, in promoting a holistic approach to the lived individual. Would it not be an unrivaled position to study pain and other types of suffering in a context where detailed biomedical knowledge about the complexity of life, seen from the perspective of the body, is combined with an approach to an individual's experiences in social life?

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