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Towards an Understanding of Sudden, Unexplained, Prolonged Pain in a Muslim Context

Dani Khanafer

**Thesis submitted to the
Faculty of Graduate and Postdoctoral Studies
In partial fulfillment of the requirements
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**Department of Sociology and Anthropology
Faculty of Social Sciences
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Abstract

This thesis examines how Shia Muslims react to sudden, unexplained, and prolonged pain. In doing so, the thesis frames physical pain not only as physiological phenomenon but also as a phenomenon that is defined by historical, cultural and social context. Sudden, unexplained and prolonged pain not only produces physical hurt, it also has the capacity to interrupt individuals' social activities and as a consequence their identities and the meanings with which they are associated. For this reason, it is argued that biomedicine and psychology are not always capable of giving satisfactory accounts of the experience of pain. This failure frequently leads individuals who succumb to sudden, unexplained and prolonged pain to look for meaning in religious or quasi-religious experience. The thesis first explores historically divergent conceptions of pain. It then gives an overview of biomedical, psychological and sociological and anthropological conceptions of pain. A theoretical framework is developed that connects the experience of pain with broader social meanings, identity and the body. This framework is used to analyse qualitative data collected through semi-structured interviews with Shia Muslim scholars and Shia Muslim respondents who have experienced or are experiencing sudden unexplained pain. It is shown that the religious worldview provides believers with cultural resources that allow them to negotiate the crisis of meaning and identity provoked by the experience of sudden, unexplained, prolonged pain.

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Introduction

Even though pain and suffering are not new terms in the sociological lexicon, the study of the experience of pain has been gaining ground especially since sociology and anthropology began to question the assumptions of two-dimensional Cartesian biomedicine (the mind and body dualism). While humans might not be bound by the same joy, they are indeed linked by the idea and the capacity to feel pain. Nonetheless, the viability of a universal interpretation of pain is still not clear, especially when culture, social context, and biography are acknowledged as important factors in the shaping, understanding and interpretation of pain. In order to understand pain and its meaning, we maintain that we must understand the elements that have contributed to its historical development. The experience of pain, as we will show here, is as much a product of the effects of socio-cultural systems and individual identities as it is a physiological process. Consequently, in addition to major works in the field of biomedicine, it is also important to approach the experience of pain by drawing on the relevant works from the fields of anthropology, psychology, as well as sociology.

In this thesis, we will specifically focus on the relationship between the experience of pain and religious worldviews. The significance of this relationship is suggested by a number of contemporary scholars writing about the experience of pain who claim that compared to modern biomedicine, religious and cultural worldviews and interpretations allowed individuals to more effectively integrate pain into their everyday lives, as well as to frame it within a meaningful context (Bendelow and Williams 1995; Keefe et al. 2001; Conway 1985; Koenig et al. 1992; Heyse-Moore 1996; Puchalski et al. 2005). We particularly want to explore to what extent contemporary Islamic practices contribute to individuals' framing, experience, and understanding of pain. In order to do so, we will explore the relationships

between pain, identity (conceptions of the self), and the body in the relevant anthropological and sociological literature, and through the analysis of qualitative interview data of Muslim Shia respondents in the Ottawa region. The question regarding the experience of pain in an Islamic context remains under-researched as most of the existing literature deals with non-Islamic perspectives. And when research does deal with Islam and Muslims under a medical umbrella; it usually only focuses on how Islam as a traditional worldview represents an obstacle to the development of proper modern medical practices (Laird et al. 2007). This focus makes it hard to understand how Islamic conceptions of pain might not necessarily exclude modern biomedicine.

This thesis first explores how pain has been explained and framed historically with a special emphasis on the Christian and Cartesian conceptions of pain, and how pain theory has evolved since the twentieth century. There are two reasons for focusing on the Christian conception of pain in a thesis dealing with the Islamic conception of pain. First, as we show below, Islamic scholars were crucial to the preservation and transmission of the medical knowledges of antiquity. Second, the existing scholarship on the relationship between pain and religion and the history of pain focuses predominantly on Christianity. Undertaking a comparable analysis for Islamic civilization is beyond the scope of an MA thesis. Consequently, I will explore how the influence of Christianity wanes, and how a biomechanical point of view becomes dominant in the understanding of pain, which eventually leads to both medical and psychological understandings of this phenomenon. The value of this brief historical survey is that it also reveals how that the understanding and the experience of pain is connected to broader social, political and cultural contexts. For instance, as we will see, the ascendancy of Christianity introduced a new conception of pain and its embodiment. We will then show that problems with the understanding of pain emerge

as sociology and medical anthropology begin to question the assumptions of biomedical theory. We will show how sociology problematizes the question of pain by exploring it through the lens of body, self/identity, and religion/culture. We will also show how in a number of contemporary contexts, for instance in the context of chronic pain, the limits of the dominant biomedical understanding of pain is revealed. In order to make this research manageable and for theoretical reasons that we detail in the theoretical chapter, we will show how certain sudden, unexplained, and prolonged, S.U.P. hereafter, pain experiences and illnesses have the potential to provoke or reinforce a religious or quasi-religious account of pain experience, in which individuals search for answers beyond the biomedical framing of pain. This does not mean that individuals abandon biomedical framings of pain completely, but that they draw on other resources such as religious or quasi-religious worldviews. Thus this research will also attempt to explore why people with S.U.P. experiences of pain are more likely to move from biomedical explanations towards posing broader existential questions about the meaning ascribed to their pain experience. Finally, we will also address how concepts such as identity and the body can be used in order to develop a socio-cultural and biographical understanding of pain.

This thesis is divided into six chapters. The first chapter provides a brief account of the history of pain from Greek descriptions until the twentieth century, with a particular emphasis on Christian assumptions on pain, as well a Cartesian and post-Cartesian understanding of pain. In this chapter we also make reference to Foucault's discussion of the historical emergence of the medical laboratory and its implications for modern medicine. The second chapter will focus on the biomedical and psychological understanding of pain, and how this scientific rational approach has been problematized by studies in the sociology and anthropology of pain and the body. Within this sociological and anthropological paradigm,

medical sociology and anthropology have pioneered discussions concerning the multiple dimensions of the categories of pain, such as identity, body, and culture. In the last section of this chapter, we will deal with the emerging literature dealing with pain and religion and the link and meaning that individuals ascribe to their painful experience. The third chapter develops the theoretical framework by drawing on medical sociology and anthropology, conceptions of the body and embodiment in the work of Erving Goffman such as stigma and embarrassment. Additionally, explanations of body and identity will also be examined through various phenomenological studies in the work of Kathy Charmaz. Chapter four, the methodological chapter will relate the theoretical framework to the design of the data collection techniques. Chapter five will begin by addressing the problems facing the study of the interaction between Western biomedicine and Islam, due to bias and insufficient research. In this chapter, we will not specifically deal with an Islamic sociology per se, but we will focus on the Islamic worldview and outlook on life. This is important since the last part of this chapter will attempt to present Islamic scholars' interpretation of pain and the body by drawing on our interviews with four Islamic scholars. The next chapter will analyze the interview data focusing on Shia Muslim understanding of pain, body, and identity. This will be followed by the conclusion.

Chapter One: History of Pain

Conceptions of Pain in Antiquity

While looking at pain historically might not seem directly relevant to the research proposed in this thesis, this brief overview of the history of pain will help us to establish a key point, namely that pain has not always been understood as an exclusively bio-medical phenomenon. It has taken many historical definitions, but not necessarily a biomedical definition. Pain only emerged as a biomedical fact accompli late in the 18 century and especially in the 19th and 20th century. Consequently it is hardly surprising, that an understanding of pain was incorporated into broader cultural system, such as religion.

Looking back, the history of pain can be traced back to ancient Egypt (circa 1550 B.C.) where the first treatments for pain were historically recorded. In the Egyptian papyri, “there is a prescription of opium by the god Isis for Ra’s headache” (Turk et al. 1983: 75). While it is obvious that the Egyptians were culturally aware of pain, we should note that deeper reflection could have possibly existed during this period; however as a result of a lack of any significant historical transmission, we are historically bound to begin where the first report of human civilization emerged, in the context of Greek culture. The word pain derives from ‘poine’ or ‘poene’, which the Greeks associated with a goddess of pain (“Odyne”) and was inevitably the source of pain. Greek interpretation of pain located it in the realm of the supernatural, referring to a realm of a goddess, who could ultimately inflict an individual with or spare him or her from pain and suffering. Turk et al., discussing the history of pain, explain that ancient cultures dealt with pain through religious institutions. They assert that “religious leaders...have suggested that pain is imposed by god [or a goddess], as either a test of faith or form of punishment” (1983: 78). Consequently, in the process of alleviating

pain and attenuation of suffering, “individuals have submitted themselves to such largely ineffective and often pernicious procedures as purging, puking, poisoning, puncturing, cutting, cupping, blistering, bleeding, leeching, heating, freezing, sweating, trephining, and shocking” (Turk et al. 1983: 75).

Due to a lack of an analytical and systematic literature dealing with personal accounts of pain, the study of pain in the period of antiquity relies heavily on the interpretation of literature (e.g. Homer, Sophocles, Hippocratic Collection), as it is the only accessible vehicle of culture and thought from that period. Far from viewing it as a static element, pain was understood as a dynamic force whose powers could be felt within the human soul. In the works of Sophocles, pain is anthropomorphized into a “living being” qualified by the oft-repeated terms such as “consuming” and “devouring” its subjects. Eventually, the subject becomes weaker as pain overcomes him or her (Rey 1995: 15). Pain, then, was painted as a parasite invading the body, weakening its prey.

In the Socratic discourse of the *Phaedo* (circa 399 B.C.E), Socrates claims that “the very absence of pain was therefore pleasure” (Socrates in Rey 1995: 38). Subsequently, the philosophy of pain and pleasure was to preoccupy the two emerging and competing schools of thought, Epicureans (342 B.C.E) and the Stoics (300 B.C.E). Epicurean philosophy of pleasure rested on a number of philosophical principles and guidance points, which Epicurus conveyed in epistolary form to one of his followers, Menoecus. On numerous occasions, Epicurus states that “certain pleasures must be rejected in order to savour greater pleasures later, while some pains must be patiently endured to escape more severe ones [later]” (Epicurus in Rey 1995: 38). For Epicurus, pain was not an abstract idea; in some instances he managed to be precise when guiding his followers. In his letter to Menoecus, he elaborates on pain: “when we say that pleasure is the goal... [it is]... the lack of pain in the body and

disturbance of the soul” (Epicurus in Morgan 2001: 360). These principal doctrines can be distinguished as an Epicurean life style promoting and dictating austerity. But on a further note, this could be also understood as the building blocks of pain medicine (therapeutic and palliative care) as one must rid oneself of pain and must seek to quell and remedy it because “[f]or Epicureanism, the highest good [telos] was pleasure” and “pleasure is the starting point and goal of living blessedly” (Rey 1995:37; Morgan 2001:360). And specifically, a blessed life consists of “avoidance [of illness] to the health of the body and freedom of the soul from disturbances” (Epicurus in Morgan 2001: 360). Epicurus reasserts the following interpretation by expanding his view on joy and pain: “the pleasure we consider to be the supreme pleasure is the one we are conscious of when every possible type of pain has been eliminated” (Epicurus in Rey 1995: 38).

If it did well morally and medically, Epicurean philosophy was quickly subjected to immense scrutiny and eventually subjugated and replaced by Stoic philosophy. For Stoics the problem with Epicureanism was the fact that it outwardly rejected intense socio-political interaction in their principal doctrine by asserting on numerous occasions that “the purest security is that which comes from a quiet life and withdrawal from the many” (Epicurus in Morgan 2001:360). The continued Stoic onslaught on Epicurean austerity not only brought Christian doctrine to the social scene (as we will see below), but it also rapidly changed the tides in favour of Stoic activism and political involvement. Politically then, Epicureanism did not fare well because it was castigated as a self-centered ideology whose unintended purpose was alienating or discouraging individuals from a continued participation in the socio-political sphere. This stoic political involvement in essence paved the way for its eventual triumph over Epicurean socio-political withdrawal. This was a milestone for Christianity, as Christianity would become the dominant ideology of the era. Importantly, Stoic philosophy

only emerged as it began to echo a political message of involvement and activism to which the Christian Church gave its blessings (Rey 1995: 39).

When analyzing Stoicism, Morgan remarks that it “permeated the writings of the Church fathers and the literature of the Middle Ages. It also influenced Renaissance thought and modern thinkers as diverse as John Calvin, Richard Hooker, Michel de Montaigne, Descartes, Spinoza, and Kant” (Morgan 2001:365). This meant that to some degree the Stoic philosophy of pain was closely aligned with that of Christianity, “because an objective alliance was forged between [Stoic] critics and the new Christian morality opposed to such a philosophy [i.e. Epicureanism]” (Rey 1995: 39). This was simply because Epicurean philosophy is “based on materialistic principles and claiming to liberate mankind by restoring personal dignity which was being trampled beneath the advancing footsteps of religious superstitions” (Rey 1995: 39). Stoic philosophical attitude towards pain was none other than patience and endurance — i.e. “bear it and stay impassive” — because pain was neither within the realm of vice nor virtue, which in essence characterized the political involvement of the stoics (Rey 1995: 40). Further, in the *Enchiridion* (i.e. handbook), Epictetus elaborates on this impassivity by reminding his followers to desist and “not seek to have events happen as you want them to, but instead want them to happen as they do happen, and your life will go well” (Epictetus in Morgan 2001:368). Subsequently, this statement in the *Enchiridion* is applied in the context of the body and illness. Epictetus writes that “illness interferes with the body, not with one’s faculty of choice unless the faculty of choice wishes it to.... Say this at each thing that happens to you, since you will find that it interferes with something else, not with you” (Epictetus in Morgan 2001:369). Clearly, Epictetus’s philosophy and theory of pain is that of disassociation, namely separating the body from the self and the faculty of reason. Rather than accepting pain, Epictetus would recommend a

remedy of removal from one's body so as to keep the self busy with what is deemed important (or what could be termed as being morally good or evil).

The Stoic indifference to pain rests on a more general philosophical interpretation of good and evil. For Stoics, good and evil were pitted between virtue and vice and ultimately with virtue as the supreme good. When dealing with the two concepts of virtue and vice, pain is irrelevant, it has no value and no place. As the Stoics said: "pain is not an evil" because it can have no moral evil or good (Rey 1995: 40). One cannot morally hate pain or love pain. And since it has no existence in this higher philosophical echelon, Stoic philosophy was dead silent on this matter because all that simply mattered was virtue and morality.

Even though these schools of thought were not medical in nature, antiquity was to give birth to one of the most enduring medical legacies, Galen of Pergamum (200 AD), who became a famous physician and surgeon in the Roman Empire. His Greek medical work is extant and only translations from Arabic to Latin remain through the work of the Islamic physician Rhazes, and in his critical stance of Galen in his famous book entitled "Doubts on Galen". Galen was prolific in his description of diseases and in the types of pain involved, which he described as either "pulsific" or throbbing, "gravative" or weighty, "tensive" or stretching, and "pungitive" or lancinating" (Rey 1995:33). In 1363 Guy de Chauliac, under the "dual influence of Avicenna [a tenth century physician and Islamic philosopher] and Galen", wrote that "pain, according to Avicenna, is a feeling of contradictory qualities [pertaining to the humoural system]" and "with these contradictory humours which might inflict pain, according to Galen, there may be alterations which break or cut, stretch or abrade" in the feeling of pain (Rey 1995:46). And in this sense, "pain is therefore the result either of personally generated contrary qualities [by the humours], or interruption in continuity [in bodily functions] caused by accidents" (Rey 1995:46).

Despite this philosophical discussion on pain, medicine in antiquity was more concentrated on prognosis “because illness [was] seen as a process” (Rey 1995:20). Nonetheless, even these ancient cultures were not devoid of a means of dealing with pain. Many cultures, as attested by Turk et al. (1983), attempted to cure the pain by drilling holes in the skulls of patients — trepanation, as they believed that pain would leave the body through the opening. Even Hippocrates was aware of this method that was practiced in ancient Greece. Anesthesia was not introduced into medical practice until 1846 even though other pain relievers (such as opium from which morphine is synthesized and derived) were employed as medical techniques to subdue the effects of pain. These body-numbing techniques and other sedative methods were amply employed prior to the discovery of anesthesia.

Because of the many centers of knowledge during the Middle-Ages (namely Alexandria, Baghdad, Antioch, and Gunde-Shapur in Persia), and the infiltration of Islamic medicine in Europe through Islamic Spain and Italy (under Islamic authors such as Ibn Sina and el-Radhi, known in the cotemporary west as Avicenna and Rhazes), there arose a distinct medical practice. Avicenna through his meticulous work introduced the *Cannons of Medicine* which became dominant in Europe from the 11th century until the 17th century (the English word ‘cannon’ comes literally from the Arabic word ‘Qanoon’ which means ‘law’). In describing the effect of Islamic medicine, Rey says that Islamic medicine “harvested a much richer medical and philosophical heritage from Greece during that era than any which managed to reach the then slumbering Occident” (1995: 45). She continues: “the introduction of this Arab [Islamic] medicine in the 11th century acted as a catalyst in awakening Western thinking and subsequently its universities” (Rey 1995: 45). However, while medically-speaking Europe received assistance from the Islamic world, nonetheless, Christian beliefs

about pain came to dominate conceptions of pain, thus providing an enduring legacy (Rey 1995: 45).

It was not until the 12th century that Christianity began to develop its theological answer to pain and its effects. Attempting to explain and expound on the concept of pain to its followers, Christianity borrowed many Greek cultural elements to treat pain. While it is a Christian doctrinal and spiritual belief to revere pain, Christianity still left room for medical intervention albeit to a diminished degree. Therefore, throughout the European Middle-Ages and concurrent with the work of Guy de Chauliac, Aristotle's treatise on nature and Hippocrates' on the *Nature of Man* dominated the medical understanding of pain. Pain was understood in its emotional aspect rather than as a purely physical phenomenon. As Fernando Salamon writes, pain could be caused by the simple imbalance of the humours or the bodily fluids. He further adds that "in a medical system built upon a complexional anatomy, the humours (blood, phlegm, bile and black bile) were the material carriers of the four qualities - heat, cold, dryness and humidity — that characterized the basic elements that made up the human body: earth, water, air and fire" (Salamon 2004).

For this type of pain and suffering, cure and remedy did not fall within the strictly medical framework with respect to pain with which we are currently familiar in biomedicine. Pain was seen as integrated in an individual's life, and dependent on his or her actions. Healing was not a direct cause of medical advances; indeed it was seen beyond its grasp. Solomon notes that "common therapeutic devices that aimed to eliminate the cause of pain by restoring the humoral balance were more likely to have been used. In this respect, pain was just another ailment that would benefit from bloodletting, laxatives, purgatives and the monitoring of food, drink and sleep" (2004). But quasi "medical" techniques were not enough in the Middle-Ages, rather when these techniques did not cure the patient, healers

resorted to means that seem to our modern sensibilities as being firmly outside of the domain of science and its methods. Thus, Solomon asserts that when common medieval techniques did not work “other remedies, such as astrological seals, were thought of as being useful as painkillers because they conveyed some specific properties explained by a magical rationality” (2004).

Christianity and Pain

Before we embark on a brief historical account on Christianity and pain, it is worth noting that Christian ideology concerning pain was not cemented until the 12th century, previously pain was assumed a predominantly female feeling (Rey 1995: 49). This could mean that prior to solidifying the ‘suffering self’ and the notion of Christ’s enduring life in pain, pain could have been a derogative term used to rank women as second class citizens. It could have also been associated with terms such as weak, incomplete, underdeveloped, mysterious, evil, vile, terms that could have eventually resurfaced during the witch-burning period.

As Christianity ascended the political and social scale, it steadily developed and provided answers to the reoccurring problem of pain. As Weber shows in his sociology of religion, rationalizers and systematizers of religious systems cannot ignore the wider social and political demands and tensions of the societies in which they operate. Thus, the notion of pain underwent a dramatic shift in the twelfth century: rather than just associated with women, it was universalized. Pain embodied in the form of Christ “became increasingly focused on Christ’s Incarnation and his suffering on the Cross and may have been responsible for the appearance of a greater concern with bodily suffering” (Rey 1995: 48). This in turn could have turned pain into a subject worthy of sacred reverence in either the

form of divine retribution or as a “sign of having been especially chosen... which may have encouraged a stoic indifference to pain” as we have mentioned above (1995: 49).

Because of the intense influence of the Christian Church, there is no better way to understand the history of pain in the West than by looking at the Christian doctrine as it was the dominant cultural system that held sway over Europe for a very long time. Coming to the political scene with a strong and nascent theology, Christianity began to develop an understanding of pain. It did not only develop a divine answer to the cause of pain, it also embarked on a quest to seek remedies for ailments (even though pain was thought of as good). This Christian journey to understanding pain inevitably became the marker of difference between the Christian and Stoic school of thought. In describing pain in the early Christian era, Judith Perkins argues that Christianity developed a new self image of humanity. Humans were no longer the masters of their self but were identified with the “suffering self” (Trout 1998: 562). This new revolutionary link between the body, self, and pain was further extended to incorporate suffering as a form of valour. Dennis E. Trout, reviewing Perkins book on the Christian concept of the ‘suffering self’, writes that Christian and Non-Christian authors “began not only to represent the ‘human self as a body in pain’ but also to valorize suffering as the basis of an intimate relationship with the divine” (1998: 562). So then, it is no surprise that the medical anthropologist, Arthur Kleinman, argues that “Christian theology made of suffering not a wholly disvalued experience to be managed or negotiated, but an occasion for the work of cultural processes to transcend pain and dying” (1988: 29). So while pain in the Greek literature was something one should overcome and rid oneself of, the Christian theological understanding of pain was based on the sacrifice made by its founding figure. Jesus Christ’s pain and untimely suffering became of prime importance to his followers because those eager to follow his righteous path would have to

be able to endure severe and necessary pain. Jacqueline M. Cameron writes that “Jesus’ generous but brief life ended in severe and very public pain” and ultimately God’s communication to the world is through a suffering human (Cameron 2005: 170).

In describing Jesus, Puchalski et al. write that “Jesus Christ provides a different model of suffering. He was the sacrificial lamb who in his death took the sins of all humanity on himself. His death is what redeems humanity” (2005: 116). This religious worldview would leave the Christian follower in a more submissive position towards pain. The follower might feel angry, remorseful, but also in debt to Jesus. Logically, a suffering follower would usually succeed in re-conceptualizing his or her suffering and painful life like that of Jesus. The follower in this sense begins to share the experience of Jesus, and to endure it because the believer is aware that there is no match to Jesus’ suffering. While God’s Messiah suffered for the sins and “the evil deeds of humanity”, the individual regardless of what s/he suffers for s/he will realize that their agony and pain is in no way comparable to Christ’s. Puchalski et al. elaborate that “[b]y sharing in His suffering, the Christian deepens his or her union with God on a mystical level, as St. Paul wrote: ‘We are always carrying about in the body the dying of Jesus so that the life of Jesus may also be manifested in our body’ (St. Paul in Puchalski et al. 2005: 116). Suffering and pain might solely be used to connect to Jesus in this case. Thus a Christian’s “express” connection to God is through the suffering and pain s/he feels. Because Jesus is the Prophet of suffering and pain, this might eventually link the individual to the world of the sacred. In this way, the trials and tribulations of the profane world are given meaning through its contact with the world of the sacred. Therefore, Christianity does not deny pain nor does it try to excuse it, but actually promotes it as an ideal way of life because it inevitably “helps people cope with the pain by giving them the grace needed to bear suffering and not be overwhelmed by it” (Puchalski et al. 2005: 116).

Not all pain and suffering, however, is seen through its religious connection with Jesus. Some Christian followers view suffering and pain as a punishment and atonement for sin. However, even though this is viewed as punishment, the follower still has ample leeway to redeem their suffering. Individuals can take this opportunity to feel what Jesus experience when he shouldered all the sins and evil of humanity. Eventually, this can force the religious followers to seek means of asking and obtaining forgiveness, mercy, and healing. According to Christian scripture and theology, healing cannot be achieved through healers; healing is the “transcending of one’s physical illness” because “healing can be achieved through one’s relationship with Christ and others. Healing occurs when one deepens the virtues of faith, hope, and love. Ultimately all healing comes from God, so one can turn to God in prayer to be healed” (Puchalski et al. 2005: 116).

Descartes and Pain

As the Christian doctrine became increasingly weakened by both the advent of scientific materialism and its inability to reciprocate answers to scientific discoveries, pain was once again reinterpreted and explained, this time drawing on a physical and mechanical paradigm theory. Descartes is viewed as being responsible for introducing the modern philosophical notion of the mind-body split which lasted over 300 years until the late twentieth century, though some might claim that it still exists today. This Cartesian notion, which still lurks in many philosophical and medical texts assumes that (1) pain is not only physical but also mental (psychological), that (2) pain pathways are embedded in the body traveling a unidirectional path towards the brain (mental), and that (3) pain centres are located in the brain in the pineal gland (where reason and the soul are inevitably joined with the body), where all organs transmit their information to this centre (transmission of sensations).

Although Marni Jackson describes this Cartesian stride in pain theory as somewhat “farsighted”, she nonetheless remains critical of the Cartesian explanation and interpretation of pain (2002: 14). Jackson notes that Descartes’

hypothesis about pain signals, for instance, turned out to be a crude but correct notion of nerve fibers and neurotransmitters. But it was his theory of the transmission of pain signals that led to what is known as the ‘specificity theory’ of pain – the notion of pain as one fixed pathway or center. This idea dominated the study of pain until the last thirty or forty years (2002: 14)

On the first point, Descartes did not believe specifically that pain could be explained only in physical terms. One needed to also invoke mental mechanisms, though not imaginary ones. In a famous example, he describes a girl with an amputated forearm and the pain she felt in the missing limb (known medically as “phantom limb” where pain is felt in an amputated area): Descartes realized that the persistence of pain “seemed to come from severed extremities” which according to Descartes is indisputable proof “that ‘pain in the [amputated] hand is not felt in the soul [self] as being in the hand but as being in the brain’” (Rey 1995: 73). This means that pain is not only present physically but is equally felt within the brain because according to Descartes pain was being experienced in missing body parts. This duality of pain (mental and physical) until recently left little room for competing theories. It left no room for interpretation of emotional or cultural factors. Moreover his theory of pain was not only philosophical in nature but was also universal-rational, hence applicable to all humans (this view however was only for humans for Descartes regarded animals as automatons incapable of reason and with no soul thus without any pain sensation).

As for pain sensation, Descartes argues that peripheral organs and fine filaments of nerves are responsible for this transmission of information to the pineal gland (where the rational soul is located). The pineal gland was the location harbouring all the soul's functions and duties, and acted as the central command for the body's actions. The information was thought to be carried to the pineal gland through "animal spirits" which transported this sensation from the origin to the pineal gland whereupon the brain orders the individual to remove or move away from the source of pain. This was famously argued in an example given about a flame placed near a foot whereby

the heat opened the pores which controlled the tubes which drove the spirits to the brain and it was they which, in response, determined the spirits' transmission partly in those muscles which are used to make the eyes and head work in order to see, and partly in those that used to make the hands move and bend the entire body to protect it (Melzack and Wall 1965: 972).

This pain pathway was unidirectional (traveling from the 'outside' to the 'inside') and acted like a mechanical and geometrical pulley system. This mechanical system was not in any way related to chemistry or biology, but was more in tune with the mechanics of strings, ropes, pulleys, and contraction (force). Bryan S. Turner argues that "Descartes' view that the body is nothing other than a machine of clay and Harvey's work on the circulation of the blood laid the foundation for Cheyne's argument that the body is 'an hydraulic machine filled with liquor'" (1992: 23). In explaining severe pain, Descartes simply proposed that severe forms of pain (e.g. burns) are none other than the opening of more pathways and pores to transmit more 'animal spirits' so as to cause intense pain. However, this intense pain

which we feel and our subsequent flight from the source of the pain are not the only directives originating from our brain. Additionally, the brain also sends signals and emotions to the various organs in our body that respond according to this pain. Thus we might feel sick, or have a stomach ache, or shiver, or hurt at heart. However, this does not mean that sensation is felt in different places of the brain or the body. Sensation is felt in one place (namely the pineal gland) because it is the only part in the brain that is not physically replicated. Thus its centeredness and uniqueness makes it all the more palpable to be a centre of brain-soul activity (Rey 1995: 75).

Post-Descartian Conception of Pain

In discussing the history of modern medicine in *The Birth of the Clinic*, Foucault writes that “modern medicine has fixed its own date of birth as being in the last years of the eighteenth century” (1973: xii). It is then no surprise, that in a pioneering discussion on the *Cultural Factors and the Response to Pain*, Wolff and Langely (1968) highlight that while there has always been philosophical accounts of pain scattered over the centuries, “systematic studies of pain probably did not begin until Schiff in 1858 made the definitive formulation that pain deserves to be placed in a sensory category of its own, later confirmed by Funke (1879)” (1968: 494; cf Engelhardt 2002: 63-4). An important contribution to the systematic scientific study of pain was “the discovery of pain sensitive points in the skin by Blix (1884) and Goldscheider (1884)” (Wolf and Langley 1968: 494).

With these discoveries, pain was brought under the medical sphere and away from philosophical discussion through intense and systematic scientific and medical discoveries. Thus began the era of the systematic scientific analysis of the human body. Roy Porter writing the *History of Medicine*, and in concordance with Michel Foucault’s account on the

History of the Clinic, admits that “after 1800, medical science was revolutionized by a clutch of French professors, whose work was shaped by the opportunities created by the French Revolution for physicians to use big public hospitals for research” (2006: 153). Tristram Engelhardt, claims that these shifts from traditional European medicine to modern western conception of medicine “were tied to changes in the ways in which the acquisition of medial knowledge was undertaken” (2002: 64). This rapid change in biomedical orientation was possible due to “the emergence of the laboratory, the development of controlled experimentation, and the application of tools such as statistical method to control observer bias” (Engelhardt 2002: 64-5). In this period, which focused on scientific research, pain was discerned as a consequence of and derivative from injury, and not as a cause within itself. In this way, pain became articulated and understood within a technical medical jargon. Lucy Bendin, in her article, *Pain in Victorian England*, argues that the ascendant medical profession of the 19th century began to address pain in a different way. Rather than seeing pain as a divine mystery, medical practioners attempted to understand its physiological basis because they were convinced that “in many cases, painfulness far outstripped any putative beneficent value” (Bendin 2004). What Bendin is highlighting is the increasingly dominant medical assertion that there are no benefits to be derived from pain; the drawbacks outstrip its benefit. In a similar tone, Engelhardt asserts that in this era (19th century), disease (and ultimately pain) “was replaced by an understanding of illnesses as being rooted in anatomical, physiological, and (later) bacteriological causal factors” and (2002: 64), therefore, “illness became scientifically and technologically reshaped in its meaning” (2002: 65-66).

Concurrent with the medical and scientific discoveries outlined above, pain theory was to re-emerge as a more holistic and dynamic object of knowledge. Turk, a professor of

anesthesiology, et al., commenting on modern reviews on pain literature (e.g. W. Clark & Hunt, 1971; Liesbeskind & Paul, 1977; Turk, 1975; Weisenberg, 1977) write that there are “compelling arguments that pain is not simply a function of the amount of tissue damage and that it cannot be defined adequately by specifying parameters of physical stimuli as suggested by simple sensory physiological theories” (1983: 80). The numerous research and studies conducted by Turk et al. suggest that pain should be considered as a subjective experience—rather than being viewed as a decontextualised and universal medical phenomenon. According to Turk et al., pain, far from being just a sensory input, can be caused and shaped by numerous factors such as “previous experiences”, the individuals “ability to understand the cause and consequences of the pain”, and “psychological variables.” This, of course does not mean that the medical “sensory input” should be eliminated (Turk 1983: 80). The new theory of pain proposed by Melzack, Wall, and Casey (1965) reorganizes pain around a multidimensional theory known as the “gate-control model”, which for the first time in 300 years, distances medical conceptualizations of pain from Cartesian “specificity theory”. Gate-control theory is very much biomedical in nature as it defines pain as a sensory element. The difference with respect to rudimentary Descartisianism is related to the availability of more complex bio-medical understandings of what is going on “inside” the body. Turk et al. in summarizing Melzack’s gate-control theory argue that it “proposes that a neural mechanism in the spinal cords acts like a ‘gate’ that can facilitate or inhibit the flow of nerve impulses from peripheral fibers to the central nervous system” (1983: 81). However, “[w]hen the amount of information that passes through the gate exceeds a critical level, the neural areas responsible for pain experience and response are activated” (1983: 81).

Although this new pain-paradigm has shifted the focus to a post-Descartian explanation of pain, it has been characterized as excessively speculative and has received much criticism from medical researchers (e.g. Kerr, 1975; Liebeskind & Paul, 1977; Nathan, 1976; Weisenberg, 1977). However, it has also received much positive attention due to its emphasis on the multidimensional nature of pain and for considering a variety of components (i.e. social/psychological factors) “and not a function of any particular system alone, but rather, that each specialized portion of the entire nervous system contributes to the pain experience” (Turk et al. 1983: 82).

Medicine, pain and power

Biomedical history cannot be simply understood as a mere product of the development of philosophical conceptions and the natural sciences, as Foucault argues, it also belongs to a more complex system of power and control. While philosophy and the natural sciences have been important in the development of biomedicine, the political and social institutionalization of biomedicine in this context has enabled strategies for the control and regulation of the behaviour of individuals and populations. In this section we provide a brief account, drawing on Foucault and others, of some of the most salient features of this process. We do not however directly draw on Foucault in our literature review or our theoretical framework. The work that we have Foucault do in this thesis is descriptive rather than analytical. In other words, he provides a compelling account of the institutional emergence of medicine and how biomedicine becomes a dominant mode through which individuals understand their bodies.

Foucault, writing on the history of sexuality, problematizes medicine’s penetration into human sexuality. In discussing the medical intervention in “pleasures”, he writes that

“medicine made a forceful entry into the pleasures of the couple: it created an entire organic, functional, or mental pathology arising out of “incomplete” sexual practices” which in a sense mirrors the trend in biomedicine to “medicalize” human nature (1990: 41). He continues, that this culminated in an “additional ruse of severity, if one thinks of all the agencies of control and all the mechanisms of surveillance that were put in to operation by pedagogy or therapeutics” (1990: 41). This panoptical power that biomedicine has achieved over the past century could firstly be analyzed as a continuous and rigorous evolutionary process of controlled research (presenting itself as objective, rational, and seeking ‘truth’), and secondly as an instrument in the shaping of biomedical discourse and its ability to frame bodily experience in terms of illness in the context of what Foucault has identified as the ‘clinical gaze’. While these underlying power relations of biomedicine are not outwardly manifested, humans feel this tremendous pressure and effects of biomedical power through the increased delegitimation of experience (Ware 1992).

Biomedical research has developed a process for legitimizing its research. This process is not any process but it is a ‘rationalized’ and ‘objective’ process that investigates illness and disease through a series of specialized observational techniques and through a standardized routine available within the confines of the modern laboratory, hospital and the emergence of a state rationality concerned with the well-being of the population. Engelhardt highlights the importance of the laboratory as a site for the production of legitimate knowledge. He argues that “laboratory research became basic to clinical investigation. In the process, the medical laboratory sciences were reconstituted as the ‘fundamental sciences’ or basic sciences – that is, those sciences foundational to understanding the surface world of clinical realities and patient experiences” (2002: 65). Through this precise articulation, biomedicine has steadily reserved the special right of ‘medicalizing’ an illness upon

detection. This tedious and arduous process has produced a rigorous systematic categorization, compartmentalization, and determination of illness, medical or 'other'. This controlled research not only defines and shapes illness but also has acquired the ability and the institutional power to shape broader discourses on illness. Tuner writes that "for example homosexuality was regarded as a sin under Christian therapy, as a behavioural disorder by early psychology and as merely a sexual preference by contemporary medicine" (1992: 11).

Hence, in the course of the development of biomedical discourse, illness is isolated in the laboratory and scrutinized from the perspective of its mechanical and technical functions from a western based rationality. The result is that the modern laboratory has been able to isolate and manipulate nature within the confines of four walls and utilizing scientific instruments of investigation. Because of this excessive division and compartmentalization, the modern laboratory has been the scene of an objective process that is presented as being disassociated from bias, emotions, and 'non-scientific' means of investigation. Thus the use of the laboratory has become the medium by which nature and increasingly our bodies have been explained, and presented to western society. On this point, Engelhardt asserts that "the two-tier world of clinical experiences and laboratory realities placed the lived, directly experienced, clinical world of the patient and the physician apart from the highly scientifically and technologically constructed world of the laboratory" (2002: 65). Making it the only medium by which we understand our nature and illness, biomedical power has tremendously increased its rejection of all 'other' explanations that do not travel through this 'rational' and 'objective' explanatory medium. As Turner, drawing on Foucault, asserts 'things' "depend on how they are defined; how things are defined depends on how the general culture allocates phenomena within the spaces of convention. If we adopt this theory of knowledge, then disease is not a pathological entity in nature, but the outcome of socio-

historical processes” (1992: 11). The scientific legitimization of the monopoly of knowledge and nature has without doubt left biomedicine as the undisputed authority in creating, shaping, analyzing, and understanding illness and its process. And because “the laboratory was accepted as having the power to legitimize clinical finding and patient complaints, the laboratory transformed the experience of illness in terms dictated by the new basic sciences” (Engelhardt 2002: 65).

The power of biomedicine and the birth of the clinic have certainly reinforced medical authority over our bodies through the “clinical gaze” or the “observing gaze” (Foucault 1973). This gaze was unique and was reserved for the emerging group of professional doctors. It allowed doctors to not just look at an individual through the body and to assess their medical condition but to also look ‘into’ it. Chris Philo, commenting on *The Birth of the Clinic*, writes, “from now on, a defining role of the doctor would be to subject suffering patients to the most rigorous and exacting of medical gazes, which in the majority of cases would look not just at the body but into it as well” (2000: 13). Foucault writes that “it was this constant gaze upon the patient, this age-old, yet ever renewed attention that enabled medicine not to disappear entirely with each new speculation, but to preserve itself, to assume little by little the figure of truth ... medicine it was thought, had bound truth and time together” (1973: 54-55).

This sustained gaze of scientific nature presented itself as a practical knowledge, and as an objective or an eternal knowledge that was not to be questioned or doubted. Foucault continues, this clinical gaze “presented itself as the restitutions of an eternal truth in a continuous historical development.... It masked that other history by assimilating to clinical method all the study of cases... it authorized all subsequent simplifications whereby clinical medicine became simply the examination of the individual” (1973: 57). Philo adds that “the

hospital was reinvented as a space of sustained clinical activity, lined into an explicit teaching function, whose... patients were seemingly looked upon more as objectified sources of data than as unwell individuals wanting to have their suffering alleviated” (2000: 17). This ‘clinical gaze’ however cannot be understood in its own terms as an objective practice; it is the product of language, practices, culture and power. Thus there exists no gaze without bias, without a historical background. The gaze is indeed subjective and is the result of socio-political forces that emerged within the western medical cultural system. Foucault attests that this clinical gaze “is not that of an intellectual eye that is able to perceive the unalterable purity of essences beneath phenomena” (1973: 120). The gaze is more of a “concrete sensibility, a gaze that travels from body to body, and whose trajectory is situated in the space of sensible manifestation. For the clinic all truth is sensible truth” (Foucault 1973: 120). Simply then, the gaze “implies an open field, and its essential activity is of the successive order of reading; it records and totalizes; it gradually reconstitutes immanent organizations; it spreads out over a world that is already the world of language” (Foucault 1973: 121).

Undeniably, there is an underlying problem concerning the purity and soundness of modern scientific knowledge production. Foucault claims that science assumed additional responsibilities because “it set itself up as the supreme authority in matters of hygienic necessity... it claimed to ensure the physical vigor and the moral cleanliness of the social body” (1990: 54). However, medical knowledge’s ability to speak objectively about individuals has not been without opposition. Myriad of sociological and anthropological works have concluded that the medicalization of illness and the individual experience of pain need to be questioned (Charmaz 1983, 1994, 1995; Shilling 1997; Morris 1991). While biomedical power does shape our behaviour, it cannot do so completely; sociological and

anthropological studies have been instrumental in identifying the sociological and cultural aspects of pain and disease as a lived bodily experience by deconstructing biomedical power and discourse.

Looking at pain historically serves as an important research tool to highlight, in this case, that medicine has not always had a monopoly on pain; pain has a social history. This means that pain was not strictly interpreted through one common definition throughout history, different epochs brought with it new definitions of pain. However, what is interesting in twentieth and current century, is the mono-influence of biomedicine on the medical system and nosology, which has essentially restricted the definition of pain to a biomedical framework. In the next chapter, our literature review, we explore attempts to expand the definition of pain in the context of psychology, sociology, anthropology and the sociology of religion. These attempts will be used in developing our theoretical framework in chapter three.

Chapter Two: Defining pain

Biomedicine and pain

In many ways, Descartes' legacy is still with us. His conception of pain as both a mechanical and mental process are still today dominant modes for socially understanding the experience of pain through the fields of in biomedicine and psychology. In this chapter, we first review the biomedical and psychological literature. We then go on to review the sociological and anthropological literature that claims quite convincingly that pain needs to be conceptualized as a social cultural phenomenon, and that it is not exhausted by mechanical materialist and mentalist accounts. Thus we review the literature on pain in the medical and psychological fields. We then look at sociological accounts of pain and suffering as well as the work that comes from medical anthropology and the sociology of medicine, which speak to the need to understand pain in a multidimensional way. This focus is further developed exploring literature that deals with the individual phenomenological aspect of pain and the relationship of pain to the body as it relates to the performance of social roles. We conclude the review with an overview of the sociology or religion because as we show below, the experience of pain can often provoke questions of a religious or quasi-religious nature.

Beginning with biomedicine and before continuing, it is important to note that biomedicine here refers "to the predominant medical theory and practice of Euro-American societies, a medicine widely disseminated through out the world" (Hahn and Kleinman 1983: 305). Its main and ultimate focus is "on human biology, or more accurately, on physiology, even pathophysiology [which is the branch of medicine that deals with the essential nature of disease]" (Hahn and Kleinman 1983: 306). Although Kleinman and Hahn admit that there are numerous modern ethnomedicines that "evidence 'scientific' approaches", the principle

difference is that they may be “cast in different orientation” like contemporary Chinese medicine which incorporates other traditional elements like human spirit and soul (1983: 305-6). Thus biomedicine nonetheless remains a Western and Euro-American tradition that is “spread widely elsewhere” (Hahn and Kleinman 1983: 306).

It is then safe to say that biomedicine is a western socio-cultural approach to healing and health relying on a materialist philosophy and worldview. In the western biomedical conception of health, suffering and pain are not diagnostic areas; rather they are seen as neurological symptoms. For Hans-Georg Schaible and Frank Richterthey, “[p]ain is the sensation that is specifically evoked by potential or actual noxious (i.e. tissue damaging) stimuli or by tissue injury” (2004: 237). Further, the authors elaborate on the medical perspective on pain by adding “the ‘pain system’ should be called the ‘nociceptive system’ because pain is a subjective result of nociception. Nociception is the encoding and processing of noxious stimuli in the nervous system that can be measured with electrophysiological techniques” (2004: 237). For medical science, pain can be controlled or temporarily halted by the use of different therapies (e.g. surgery, “blockage of pain pathways by ‘analgesic agents’”, or removal of brain parts responsible for signals – thalamus). Discussing further scientific studies on the topic of pain, Good et al. claim that “neuroscientists regard pain as a salient feature of the nervous system. It thus becomes reasonable [in the medical sense] to assume that pain is a universal feature of the human condition” (1994: 1).

Anthropologists Robert A. Hahn and Arthur Kleinman, however, claim that biomedicine is historically rooted in a materialist paradigm of life and the world, and thus of illness (and pain). This philosophical trait is quite important when attempting to understand the biomedical conception of pain because the cornerstone of biomedical practice has grown

out of this cultural approach and philosophical root. Materialism, then, stipulates that all phenomena and reality derive in essence of material roots and that every single event in the cosmos has a material reality. Even ideas or words such as “life” or “culture” or “consciousness” are not beyond the reach of material explanation and can be replaced respectively with materialist connotations like “physiochemical”, “observable behavior”, and “neural firings” (Hahn and Kleinman 1983: 307). All things that might seem nonmaterial to us can within this paradigm ultimately be reduced to a physical material cause. In so doing, it reduces humans to simpler forms of being, thus hiding their complex nature. Biomedicine, in adopting this philosophy of pure materialism has concentrated the bulk of its endeavours and research on the material body culminating in the split and isolation between the existential individual and the individual as physical material research object. While attempts at understanding humans through their physical material components can be useful and correct in some respect, they fail to grasp the significance of the socio-cultural dimensions, identity dynamics, and the social relationships in determining body behaviour and ultimately pain behaviour.

Even though materialist philosophy has evolved to include other non-material elements within its scope, it nonetheless retains the prerogative to interpret them in physical material terms. It does this by redefining nonmaterial things such as “relationships”, “ideas”, “values”, and “feelings” in “terms of material phenomena” (Hahn and Kleinman 1983: 308). Ultimately, this material explanation of the world (both material and nonmaterial) are all posited and transcribed in material relations.

Through our brief discussion of the philosophical foundation of biomedicine, we have been able to show that biomedical therapy and treatment does not include any nonmaterial elements in its explanatory discourse. Even nonmaterial aspects (of pain) are

strictly explained through material phenomena. Biomedicine's scientific and rational-observable approach to disease leads to a certain disregard of pain, other than as a neural process. R.W. Wilcox, the first president of the American Congress on Internal Medicine "proclaimed the dependence of medicine on the natural sciences and their 'legitimate applications to that complex category of physiochemical relationships which we call life'" (1983: 307). Furthermore, Hahn and Kleinman state that biomedicine is not wholly concerned with the general well being of the individual rather it is only concerned with "their bodies in disease" and not in pain (1983: 312). Thus, rather surprisingly, pain has not been a central concern of biomedicine. Indeed, until very recently it was not even taught in medical school (Morris 1991). Thus in this field of work, medicine is seen "as the restoration of altered anatomy or physiology" and it is also assumed to be a "logical, value-free activity" (Kleinman 1983: 313).

Specifically, biomedical practice is mainly concerned with the physiological aspects of the body and less so the psychological or socio-cultural dimensions. Consequently, it is not surprising to discover that some authors argue that, "in this era of scientific progress, there is more litigation, dissatisfaction, and complaints. Medicine has lost focus on the person and their experience of illness. It responds inadequately to patients' need to find meaning" (Hemmings 2005: 92). Biomedicine sees the body as an apparatus that can be placed under the surgical table or manipulated by medical tools and instruments. In this regard, Mariet A. E. Vrancken, in her article on *Schools of Thought on Pain*, notes that "[i]n dealing with patients who suffer from 'chronic', 'intractable' or 'inexplicable' pain, medicine seems to be confronted with the limits of its own theory and practice. Metaphorically, we may speak of the 'pain' of medicine, considering its inability to cure these patients" (1989: 435).

Psychological Definition of Pain

However, pain as an object of analysis has not been limited to the bio-medical field. It has also crept into the complex field of psychology. Since pain is a subjective experience, scientific medical research has encountered numerable obstacles and difficulties in terms of defining it as a concept. As a result of the inconsistency of the definition of pain, the International Association for the Study of Pain was established to enhance and supplement the pain literature, improve pain therapy, and to specifically address the complex and intrinsic nature of pain. The IASP shifted the focus from the earlier dichotomous idea that pain is either somatogenic (of physical origin) or psychogenic (of mental origin), namely based on the Cartesian “Specificity Theory”. Jacqueline Cameron, an associate medical director, suggests that “[p]ain is both sensory and emotional” namely because current psychological literature views pain as a multidimensional concept that is deeply linked to the central nervous system, emotions, cognitions (thoughts), and beliefs (‘socialization’) (2005:169). As a result, the IASP defines pain as “an unpleasant sensory or emotional experience associated with actual or potential tissue damage, or described in terms of such damage” (Cameron 2005: 169).

From a more psychological perspective, the Diagnostic and Statistical Manual of Mental Disorders (known as DSM IV-TR) lists pain as a mental disorder (due to the fact that psychological factors are thought to play a crucial role in the onset and development of pain under the classification of somatoform disorders. The term “somatoform” means that symptoms and ailments are physical, but are not viewed as a result of a general medical condition. To require medical attention or therapeutic intervention, pain has to be present in one or more location in the body. However, Cameron suggests that researchers have found

that “[t]he fundamental pattern that underlies the experience of pain – from the painful or noxious stimulus to perception – is transduction, transmission, modulation, and central representation” (2005: 169). These are simply the complex mechanisms through which pain is channelled back and forth, between the brain, the nervous system, the pain trajectory, and the origin of pain.

More generally, the bulk of psychological studies have focused on techniques and treatments aimed at understanding and reducing pain through a variety of cognitive strategies for coping with the effects of pain (e.g. Imaginative inattention, Imaginative transformation of pain, Imaginative transformation of context, etc...) (Turk et al. 1983: 85-90). What is common among these various coping strategies is the frequent assertion that mental distraction or temporary mental withdrawal “can increase pain tolerance” (Turk et al. 1983: 90). Turk et al. state the following: “this distraction has been related to the ‘right of way of dominant stimuli’ which precisely is attributed to the dominant distraction and to ‘law of prior entry to consciousness’” that suggests that mental priority given distraction can overtake conscious pain sensation (90).

However, a psychological definition seems to fall short from giving us a comprehensive understanding for pain. One of the important contributions that psychology has provided to our understanding and our ability to treat pain, is that not only does pain possess a mental component (and not just physiological-anatomical component) but pain is very much conditioned by our thoughts (known in psychology as “cognitive-behaviour”). This sort of psychological breakthrough does provide pain literature the added assumption that cognitive processes and pain are very much intertwined. However, the thoughts and the conditioning of our ‘cognitive-behaviour’ and subsequently our pain behaviour do not sprout in socio-cultural voids. They are heavily affected by culture and the socialization processes

through which every human has been conditioned. Simply put, our general upbringing as well as our social and cultural roots affect how we understand, assess, and react to pain, and ultimately how we determine what is painful.

Because of the inability of both the biomedical and psychological perspective to fully explain to us the meaning of pain, sociological and anthropological studies, through their research on pain, have amassed a plethora of research that not only question the biomedical account of pain, but also adds a cultural dimension to it as well.

Sociological Approaches to Suffering and Pain

There are two distinct sociological approaches to pain and suffering. The first not only treats pain but also includes the more general concept of suffering. Suffering is generally associated with universality of emotions ranging from physical, mental, spiritual, social, and emotional while pain is specifically linked to a physical-biological dimension. Thus in sociological terminology, not only is pain related to the physical aspect to human suffering, but suffering is also examined in a much wider sociological context. Iain Wilkinson writes that “phenomenologically speaking, pain is conceived to have a specific bodily place whereas the locus of suffering is held to be far more extensive than this” (2005: 21). In this case suffering is not restricted to bodily sensation but also includes our experience of self and our sense of personhood (Wilkinson 2005: 21).

In contrast to biomedicine that “specializes in the study of disease and therefore of certain sufferings” and deals with a “relatively small part of all suffering” which “concentrates upon diseases of a physical nature” (von Wiese 1934: 224), suffering in the sociological domain is seen as encompassing a large spectrum that includes genocide, war, famine, oppression, as well as economic, social, political, and cultural deprivation.

Sociological researchers have tried to objectively understand the meaning of suffering, but have come short in their attempt to fully explain it and to some extent understand it because “sociological research into suffering cannot, however, deal with disease of the human body alone, but must study all varieties of human suffering” (von Wiese 1934: 224). And because of the immensity of such a task, it seems that, “we may here be faced with the paradox that while suffering is an inevitable part of our experience of culture”, there remain some elements in “suffering that resist cultural articulation; a part of suffering appears to exceed the creative bounds of cultural expression” (Wilkinson 2005: 29).

To understand and explain suffering within a sociological framework is not without difficulty. Some sociological scholars in attempting to understand the social intensity of suffering have even asserted that “we may justifiably designate suffering the fundamental problem of sociology” (von Weise 1934: 222; Muller-Lyer 1924). At first glance, suffering is both socially constructed and subjective and can be extremely difficult to relate in words and discourse. Suffering and pain are conditioned by the multiple factors that are inherent in each society because “frequently one can recognize the same common cause of many separate, individual fates” (von Wiese 1934: 224). This general trait attributed to each society can contribute to the social conditioning of suffering and pain. Von Wiese reiterating this commonality says that social scientists “will not be at all surprised by the knowledge that personal sufferings, physical as well as psychical, largely originate in the life human beings lead in common, and therefore often have similar causes and effects” (1934: 224). But no matter how we describe pain and suffering, all societies experience a barrier in conveying their pain-experience. To a large extent, this language constraint in conveying our feelings about pain and suffering stems from contemporary cultural constraint since pain is heavily medicalised. To this difficult task, Wilkinson notes that “there is clearly no agreement among

commentators as to how we should interpret the cultural significance of the analytical frustrations that arise within the attempt to make the lived experience of human suffering a topic of debate in social science” (2005: 30).

Some sociologists define this lack of understanding and inability to cope with suffering as a cultural lack because in the Judeo-Christian era suffering was more readily understood and acknowledged by recreating the self as a ‘suffering self’. In other words, our culture lacks the cultural historical baggage to frame it within a conceptual and meaningful terminology since suffering is no longer understood as it is in a purely religious framework (Wilkinson 2005: 33). Thus the questions: of *why or why me or why this and that* are not given adequate or satisfying answers within contemporary medical and cultural settings. Foucault in talking about cultural and discursive constraints, says that our reality and hence our social construction of society is heavily indebted to the discursive constraints which shape our view and understanding of reality (Turner 1992:11).

In contrast, medical sociological and anthropological studies have explored pain in great empirical detail by trying to explain and interpret the relevance of various factors (such as self/identity, embodiment, culture) and through anthropological cross-cultural studies that have sought to investigate alternative understandings and explanations of pain.

Medical Sociology/Anthropology

While the anthropological approach to pain and suffering differs from that of sociology, they are nonetheless very well interconnected. Anthropological studies such as those conducted by Arthur Kleinman and Robert A. Hahn, have demonstrated that biomedicine is not only a biological or medical practice, but a cultural one as well. In his book on *Illness Narratives*, Arthur Kleinman writes that

mental illness in Chinese culture carries strong stigma, which, unlike the stigma of mental illness in the West, affects not only the person who is ill but the entire family. The family with a mentally ill member is regarded as carrying a hereditary taint of moral failure and constitutional vulnerability (1988: 108-109).

Thus the field of medicine is not objective in the sense idealized by scientific discourse, but like any other social practice it actually borrows from or owes much to its cultural heritage. The authors claim that “in calling biomedicine ‘a socio-cultural system’, we do not deny its physical material aspect. Rather we are exploring its socio-cultural aspect” (Robert and Kleinman 1983: 312). To this Byron J. Good, in his book entitled *Medicine, Rationality, and Experience*, adds that “Western medicine understands the body as a complex biological machine” while others might see this differently like “the Zinacanteco — a tribe in west central Chiapas, Mexico — see the body as a holistic integrated aspect of the person and social relations” (1994: 26).

A similar study on the *Cultural Factors and the Response to Pain* (Wolff and Langley 1968) investigates this cultural approach to pain and attests to the cultural dimension of pain. In exploring these cultural dimensions of pain, Wolff and Langley write that “an impressive fact emerging from investigations involving a large number of healthy individual and patients with arthritis, has been the difference in the pain response due to cultural factors” (1968: 495). Furthermore, in another study reviewed by Wolff and Langley on “pain and skin potential responses to electric shock” on sixty housewives from different origins (British, Irish, Italians, and Jews), conducted by Sternbach and Tursky (1965), found “consistent difference among the groups, both at pain threshold and pain tolerance levels....

Italian women differed significantly” from all other women. In analyzing their cultural differences to pain, Sternbach and Tursky explained that the British “tended to have a matter-of-fact attitude toward pain” which differed from the Italians because they “focused on the immediacy of pain” while the Jewish housewives resembled British and the Irish” in their experience towards pain (Wolff and Langley 1968: 496). These cultural differences and the variant responses to pain were also manifested in a second study conducted by Lambert et al. (1960). In this study of a 160 female undergraduates (of Jewish and Protestant background), the researchers, emphasizing the pain tolerance of one group over the other, claimed that “Jews tend to increase their pain tolerance when told that Jews take less pain than non-Jews, but are quite satisfied with the status quo when told that Jews can take more pain” (Wolff and Langley 1968: 497). But when Protestants are made aware of this religious difference to pain, “they strive to increase their pain tolerance, even if they know that supposedly they can take more pain to start with” (Wolff and Langley 1968: 497).

Wolff and Langley in analyzing these reviews admit that “cultural factors in terms of attitudinal variables whether explicit or implicit, do indeed exert significant influences on pain perception” (1968: 498). This means that pain is no longer just a medical condition but in most cases it is as cultural in its meanings and experience. Pain is then conditioned by society and to a larger degree prone to social constructionism “because all reality is socially constructed, as a consequence of Man’s [sic] incompleteness” (Shilling 1997: 177).

In a similar study on the clinical study of pain among 103 Americans, Italians, and Jews, Zborowski (1952) noted that “hospital staff members stated that both Italians and Jews tended to overreact to pain, to be emotional about pain, and to complain excessively” while the American patients reported pain but “few emotional side reactions are permitted” (Wolff and Langley 1968: 499). However, upon deeper investigation, Zborowski disagreed with

hospital staff and found that “Italians tend to call for immediate relief of pain by any means, such as drugs and are happy when pain is alleviated. On the other hand, whereas Jews also seek relief of pain, they are skeptical or suspicious of the future and tend to keep complaining even after their pain has been diminished” and the Americans unlike Jews “tend to be optimistic” (Wolff and Langley 1968: 499-500). Zborowski thus concludes that “similar reactions to pain demonstrated by members of different ethno-cultural groups do not necessarily reflect similar attitudes to pain” (Wolff and Langley 1968: 500). And in summing up their review, Wolff and Langley conclude that “some knowledge of a patient’s cultural matrix can, in all probabilities, provide the researcher with insight into the general form of that individual’s behaviour. In short, it can have both predicative and interpretive value” (Wolff and Langley 1968: 500). Thus, culture and pain experience seem to be intertwined as pain behaviour can be altered depending on the cultural background of the individual. No longer can pain be the monopoly of medical theories because cultural and social theories can equally provide a meaningful framework to the understanding of pain. Thus, an anthropological and sociological approach can certainly enrich biomedicine about the diversity of human pain response and experience.

We should note that David B. Morris, in his work on the *Culture of Pain* claims that while Zborowski is often criticized and accused that “his research conceals or promotes a racist agenda” through the explicit labeling of subjects as Irish, Jews, Italians, and Old Americans, his research was crucial in determining the cultural background of pain the time (1991: 55). Morris notes that while that “the responses to pain that he [Zborowski] discovered no doubt fit ethnic or racist stereotypes that now seem very dated” their responses to pain only emerged because the “response to pain is always a socio-cultural artifact” (1991: 55). This is precisely why sociologists today cannot reproduce the work of Zborowski as

culture is dynamic and not static. On this point Morris asserts that “skeptics who complain that they cannot duplicate Zborowski’s research miss the point.... Social responses to pain will not remain unchanging because society rarely stands still” (1991: 55). This is clearly summed up in Zborowski’s own words, namely “the physiology of pain acquires cultural and social attributes, and its analysis calls for investigation not only in the laboratories and clinics but also in the complex maze of society” (Zborowski in Morris 1991: 55). Morris, thus continues, that Zborowski’s insight into pain has far reaching effects from which even biomedicine can benefit. While Morris claims that a few medical text books do contain a brief analysis of how culture influences and affects the experience of pain, medical professionals, he claims, have not completely pondered about culture’s implications. This could stem to a large degree from the fact that “medicine itself constitutes a powerful culture... that promotes its own stereotypes, such as the picture of the human body as machine (which may explain a lot about the medical mistreatment of pain)” (1991: 55).

Kleinman and Hahn, developing a similar idea, proclaim that insofar as biomedicine is the amalgamation between culture and nature, biomedicine is simply another ethnomedicine. Thus, as Vrancken (1989) notes, culture seems to define and redefine medicine over time, not only its practice but its perspective on what is medical and what is not, and ultimately its definition and understanding of pain. Vrancken, similarly to Morris, agrees that

the way the medical community conceptualizes what a pain patient is and how s/he should be treated, exemplifies how the medical community understands pain. Within medicine, philosophical reflection on pain is sparse, especially with regard to literature concerning the management of pain and pain syndromes (1989: 435).

It then would be wrong to assert that biomedicine turns a blind eye to pain, but more appropriately it simply does not have the cultural framework or the proper 'paradigm' through which to tackle it more holistically. Norma C. Ware, a medical sociologist, researching the effects of Chronic Fatigue Syndrome (CFS) in *Suffering and the Social Construction of Illness*, attests that for sufferers of CFS "the lack of recognition of the illness has meant that physicians could not definitively diagnose their condition" and in this case they "experienced this as betrayal by the medical profession and responded by consulting another doctor in search of an explanation for their distress" (1992: 351). And when they failed to get adequate answers to their chronic suffering, they looked for answers in the fields of alternative health or devised their own strategies (1992: 351). This medical vacuum has left only one possible course: pain cannot be satisfactorily captured through medical practice; anthropological and sociological studies have developed a more multidimensional approach to its study.

In this context, medical sociology has been interested in examining pain as not just arising exclusively from physiological conditions, but most certainly from socio-cultural factors (i.e. those relating to the embodiment, self/identity, and society). Gillian A. Bendelow and Simon J. Williams write that "scientific medicine reduces the experience of pain to an elaborate broadcasting system of signals, rather than seeing it as molded and shaped both by the individual and their particular socio-cultural context" (1995: 140). And Norma C. Ware also touches on this medical shortcoming when talking about the delegitimizing experience felt by chronic fatigue sufferers. She writes that "it is the standard biomedical paradigm that accounts for the delegitimizing experiences encountered by chronic fatigue syndrome sufferers" (Ware 1992: 356). Ware, echoing Hahn and Kleinman's theory that biomedicine

frames the world through a materialist paradigm, writes that “the definition of “medically invisible” bodily complaints as psychogenic and therefore imaginary is a direct reflection of scientific materialism, which accords primacy to substance, equates the real with the physically observable, and discounts or bypasses altogether the subjective experience of the patient” (1992: 356). It is perhaps because of this that Wilkinson writes on the importance of socio-cultural context by arguing that

the intimacy of the association between pain and suffering is thought to be such that there are circumstances where the effective relief of pain may not require us to concentrate so much upon what is physically or mentally ‘wrong’ with a person, but more upon the socio-cultural processes in which their bodily feelings are constituted as an experience of suffering (2005: 25).

What this precisely means is that society and culture mediate to some extent our personal experience of pain. Thus, that which medicine thought it could properly describe within its own realm has become infused with a socio-cultural dimension. The suffering that humans undergo in this manner is not so much physiological or psychological as much as socio-cultural. The idea that pain and suffering are within the domain of medicine is problematic because suffering transcends the medical realm. Commenting on this subject, Ware says, concerning those with chronic fatigue syndrome, that nothing was more devastating than the “humiliation that resulted from having their subjective perceptions and sensations of illness [and pain] either trivialized or dismissed as psychosomatic” added with the shame “that stems not from the fact of having an illness but from being told that they do not [have an illness]: their shame is being wrong about the nature of reality” (1992:353-4). But this is in a

sense normal for biomedical behaviour because biomedicine is “a sociomoral phenomena that will resist change in the absence of a restructuring of categories and definitions at the level of culture” (Ware 1992: 356). Concurrent with Wilkinson’s argument that society today has lost the cultural baggage with which to define and frame pain, Arthur Kleinman notes in *Illness Narratives*, we are increasingly medicalising more of our life experiences:

When we meet up with the resistance offered by profound life experience – the death of a child or parent or spouse, the loss of a job or home, serious illness, substantial disability – we are shocked out of our common-sensical perspective on the world. We are then in a transitional situation in which we must adopt some other perspective on our experience. We may take up a moral perspective to explain and control disturbing ethical aspects of our troubles, or a religious perspective to make sense of and seek to transcend misfortune, or, increasingly a medical one to cope with our distress (1988: 27).

One of the consequences of sociological incursions into the domain of pain and suffering is that it must attempt to understand and examine the sense of self and the identity of individual experiencing pain. In other words, it must examine the socio-cultural understanding of our suffering and pain- experience as well as investigate the constraints that culture imposes upon our pain behaviour. All these social factors have an effect on our pain behaviour especially conceptions of the self and identity and the body that are temporarily or permanently changed and disabled by the experience of pain. Gillian Bendelow, in her article *Pain, Suffering and Risk*, writes that the sociological literature dealing with chronic illness and pain offers an alternative framework and paradigm “for understanding the experience of

pain by focusing on 'lived experience,' including narratives of suffering... which includes psychological, spiritual, interpersonal and even financial aspects of chronic pain, as well as its physical aspects" (2007: 59). The author continues by asserting that this allows researchers to understand how culture impacts and informs pain and are central to an understanding of health and illness (Bendelow 2007: 68-9).

In attempting to understand the delegitimization of pain experience of individuals suffering from chronic fatigue syndrome, Norma C. Ware writes that "because everyone from time to time endures aches and pains, sore throat, feelings of depression, and fatigue, such complaints [by the patients] can be construed as minor... consequences of everyday living rather than indications of serious illness" (Ware 1992: 350). Thus most sufferers of this illness complain of being told that they "don't look too sick", "you look great", "you don't act sick", "have another cup of tea", or "there's nothing wrong on your X-ray", or maybe it's "depression" because "women have a lot of trouble with depression that could cause other symptoms" (1992: 51-2). These attempts by both society and the medical community at delegitimizing such an experience has caused immense suffering to those afflicted with this severe form of chronic pain. Some have been made to almost believe that "maybe it's all in their head" or of being "crazy" and have tried to keep their painful experience secret, which has both caused some form of alienation and social isolation (1992: 352). Ware writes that "in explaining their reasons for choosing secrecy, study participants cited the awkwardness and embarrassment (as will be noted by Goffman later) of trying to explain to someone that they have an illness whose symptoms are ill-defined [by the medical community], that has no "real" name or known cause and that... most people have never heard of" (Ware 1992:353). In concluding her study, Ware remarks that this delegitimizing experience noted by the suffering participants are similar to those associated with chronic

pain patients. As with chronic pain patients, in the absence of clear physiological factors, medical professionals define the pain as “imaginary” (1992: 257). Turner argues that “much of the claims of professional expertise in medicine rest on ‘knowledge’ of disease where this knowledge is socially produced rather than objective” (1992: 18). And Johnson supporting Turner’s argument writes that “the professionalism of medicine – those institutions sustaining its autonomy – is directly related to its monopolization of ‘official’ definitions of illness and health” and as a result of this process, a system has developed that does not recognize illness outside the ‘normal and medical’ nosology.

Transcending Dualisms

Particularly important work for understanding pain in a social context has been developed by Bendelow and Williams who in *Transcending the Dualisms: towards a Sociology of Pain*, define pain as a multidimensional object of research that encompasses the body, as a material entity, the phenomenology of the experience of pain, and pain as a social and cultural construct. Their framework brings together the various elements that have been discussed until now. Bendelow and Williams begin their analysis by highlighting the limits, though not the irrelevance, of the medico-psychological approach to the understanding of pain, which views pain as a neurophysiologic and strictly a material phenomenon. The authors argue that such a theory falls short of answering some perplexing questions about pain, namely the absence of injury (feeling pain without physical injury), the location of pain when it is different from the location of injury (physical injury in one place and pain felt in a different area of the body), and the persistence of pain (without visible medical injury). Leder’s phenomenological approach, in *The Absent Body*, supports the argument advanced by Bendelow and Williams when he asserts that pain “is usually experienced as located within

the confine of my flesh. A general indicator of tissue damage, its sensory character maybe quite independent of, and persist in the absence of, its environmental cause” (1990: 75). In their introduction, Bendelow and Williams elaborate that the “field of pain has traditionally been dominated by biomedicine” (1995: 140); and because of this medical monopoly over pain, “medicine reduces the experience of pain to an elaborate broadcasting system of signals” rather than seeing it as moulded and shaped both by the individual and their unique socio-cultural background (Bendelow and Williams 1995: 140).

Similarly, in *The Body in Medical Thought and Practice* Leder laments that “medical practice, though it has gained much over the last century in clinical efficacy, has lost something as well” (1992: 1). He claims that biomedicine “has progressively lost the human touch” (Leder 1992: 1). This means that increasingly “[p]atients are often treated in a depersonalized, even dehumanized, fashion within the modern health-care system. Their suffering is not heard and responded to; their wishes are not incorporated fully into treatment decisions; their resources for self-healing are not called into play” (Leder 1992: 1).

This inconsistency between biomedical practice and the lived reality of pain has pushed both sociologist and anthropologist into developing a more comprehensive framework towards pain as a lived, embodied, and socio-cultural experience. This approach understands pain within the context of the self, identity, and the emotions of individuals. This means that analysis must focus on the relationship between the body and identity. Bendelow and Williams, usefully, draw on the phenomenological approach of Leder (1984-5; 1990; 1992) with the insights that it has for addressing the problems related to the body in modernity. For Leder, the body is characterized by its absence as a source of direct experience in our every day lives. Leder writes that people are usually not aware of their body: “nor are [they], for the most part, reflectively aware of [their] own ‘I-ness’ while

performing [actions]” (1990: 46). He further elaborates how individuals have two sides to their self because “[they] cannot act from [their] inner organs in the way [they] do from [their] surface musculature. Though [they] can lift [their] arm without any problem, [they] cannot in the same way choose to secrete a little more bile or accelerate [their] digestion” (1990: 48). This sort of body “dys-appearance” actually creates a barrier between the body and individual. This is not a forced barrier but a sort natural barrier since bodies operate independently from the self, which can serve only to mask the bodies from the self. In other words, individuals typically temporarily forget about the existence of their bodies. Leder quoting Ricoeur explains that

in effect, it is extraordinary that life functions in me without me, that the multiple hormone balances which science reveals constantly reestablish themselves within me without my help. This is extraordinary because at a certain level of my existence I no longer appear to myself as a task, as a project. I am a problem resolved as though by a greater wisdom than myself. This wisdom is a nourishing one: when I have eaten, it is not up to me to make the food into myself and grow on it. It is a wisdom of movement: the circulation of my blood and the beating of my heart do not depend upon me (Ricoeur in Leder 1990:46).

It is only when factors such as pain, death or disease surface that the body reappears as a site of a problematic phenomenological experience. Leder asserts that “a medical mishap can suddenly awaken us to the significance of such bodily lacunae” because pain and disease appear as an obstacle that threatens to rearrange our relationship to the world. As Buytendijk writes, “being ill is before all alienation from the world” (Buytendijk in Leder 1990: 80). For

Leder, individuals tend to have a hermeneutical and pragmatic reaction. In other words, they attempt to discover the meaning of the pain and then attempt to overcome or master it.

Buytendijk supporting the work of Leder, in *Pain: Its Modes and Functions* writes that “the organs of the body, the heart, kidneys, stomach, function in a manner which is hidden and unconscious as far as I am concerned: now they refuse to serve, they are in revolt against me: they torment me and rob me of my power over myself” (1962: 26). But Buytendijk also realizes that this abandonment of the human body to pain “has its direct result in a cleavage of the self and the body” (1962: 26).

For Leder, pain brings the body back to the forefront of individual experience because pain can cause parts of the body that had previously been silent to “speak up” (1990: 71). But Leder realizes that pain does more than just make us aware of the existence of our body, it also changes our relationship with it and society: severe pain and chronic illness have the devastating ability to “reorganize our lived space and time, our relations with other and with ourselves” because “the disruption and constriction of one’s habitual world thus correlates with a new relation to one’s body. In pain the body or a certain part of the body emerges as an alien presence” (1990: 73, 76). In a similar vein, Kotarba (1983) analyzing pain biographies, describes the process through which individuals first perceive pain as transitory, linking it to some physiological cause. When the pain persists, it is followed by the “emergence of doubt”, and the quest for alternative explanations. In this sense pain ceases to be understood by itself; it is understood through a multitude of different elements which provides a richer understanding. From this perspective, pain ceases to be constrained by the dualistic nature of mind and body. Pain is no longer universal (in the medical sense); it is subjective and transformative with the ability to do more than just physically hurt but also to interrupt a person’s activities, and in some instances transform an individual. It can

also put in question previously held conceptions of social reality, introducing new questions as an individual tries to make sense of the confusion that pain can generate. Leder, knowing that individuals will attempt to attach meaning to their pain, quotes Bakan who writes that “pain forces the question of its meaning, and especially of its cause, insofar as a cause is an important part of its meaning” (1990: 78). More importantly is the fact that in instances where pain is intense and its “causes are obscure, its demand for interpretation are more strident, manifested in the person suffering asking “why?” Thus, our very effort to understand the nature of pain is natural, much as it is natural for man [sic] to concern himself with disease” (Bakan in Leder 1990: 78).

In addition to the phenomenological dimensions, Bendelow and Williams also argue for the necessity of exploring the cultural context of pain. As Kleinman argues, “[i]llness takes on meaning as suffering because of the way this relationship between body and self is mediated through cultural symbols of a religious, moral or spiritual kind” (1988: 27). Pain, then, becomes culturally attached to symbols and meanings which are both personal and social.

Body and Pain

As we have noted above (Leder 1990, 1992; Buytendijk 1962; Bendelow and William 1995; Kleinman 1988), because most pain that we experience is almost always related to the body, it is equally important to look at pain through the relationship between the body and identity. This is because S.U.P and severe chronic illnesses reshape our identities and, more specifically, alter and disrupt the normal functions of our bodies. It is important then to investigate how social constructionism binds individuals to their bodies and provides them

with a sense of self. To a large degree, we have already explored the role of pain and the body. Traditionally, religion regulated much of the understanding and social interaction of the body. It served as the medium that explained and made 'sense' of our relation to our body and its daily functions. Thus it initiated restrictions and norms that brought together the self and the body. As Shilling notes, religion was an important source of self-identity that located embodied individuals in "trans-personal meaning structures" (1997: 179). However, with modernity's encroachment on the role of religion in the daily lives of individuals, medicine and other cultural institutions have taken the traditional role of religion. Whether, they have successfully achieved their aims or not is not our concern here. Shilling notes that notwithstanding that we now possess more technological means than ever with which to exercise control over our bodies, contemporary society and its associated technologies are also responsible for deconstructing the body, leaving us unsure of how we should control them (1997: 3). However, even though individuals, and to a larger extent social and medical scientists, might lack a complete picture of what the body *is*, individuals nonetheless still attach meaning to their bodies. In this respect, Shilling discussing Berger's work on the body and culture says that "irrespective of their cultural and historical location, humans are seen as having a psychological need for meaning which compels them to act" (Berger in Shilling 1997: 176). Moreover, as Turner notes, "Berger's social actors are 'burdened creatures who require the relief of culture'" (Turner in Shilling 1997: 176).

We have already discussed the relationship between the self and the body from a phenomenological perspective when discussing Leder's work. We now turn to a discussion where the body is seen as carrier of social meanings and social relations through a brief discussion of the sociology of the body.

One of the features that facilitates the distinction between self and body and that underpins the phenomenon that Leder calls the dys-appearance of the body is the fact that our “physical” self or body executes a variety of functions without our conscious control — e.g. circulation of blood, breathing, vital functions conducted by our organs like the heart, stomach, liver; brain activity as well as brain as a command centre for the entire body. Referring to Leder’s and Buytendijk’s concept of independent bodily functions, Jonathan Herring and P.-L. Chau write that “[o]ur bodies are constantly changing. It is insufficiently appreciated that our bodies are not static organisms... Our bodies continually change with cells dying and falling off, and new cells being created” and, therefore, “[b]y the time we die, there is little of us that is biologically the same as when we were born. We have only limited control over our bodies (2007: 51). Because bodies seem to be independent to some degree from our complete control, different cultures attempt to cement deeper relations between these two quasi-independent entities, i.e. self and body.

Because “human embodiment provides at least the potential for communication and shared experiences, however, bodies are inhabited and treated differently both within and between social systems” (Shilling 1997: 23). These different forms of embodiment are related to what Marcel Mauss referred to as “techniques of the body.” For Mauss, “cultures have specific ‘techniques of the body’ which provide their members with identities, govern infancy and adolescence and old age, and inform such activities as resting, talking and walking” (Marcel Mauss in Shilling 1997: 23). According to Crossley, ‘body techniques’ are “forms of practical reason. They are forms, however, which, in Mauss’ words ‘vary between societies, educations, proprieties and fashions, prestige.’” (2007: 86). This means that ‘body techniques’ are certainly rooted in cultural contexts which provide rationalization, symbolic significance, and normative regulation (Crossely 2007: 86).

In trying to understand the social role of the body, social scientists are increasingly starting from the premise “that the body is a receptor, rather than a generator, of social meaning” (Shilling 1997: 70). This means that the body does not shape society but is shaped by the social relations of a society. The body is, then, “shaped, constrained and even invented by society” (Shilling 1997: 70). This theoretical approach, widely used by social scientists as a paradigm to investigate and understand the body, assumes that individuals and the meanings we attribute to our social bodies are social products (Shilling 1997: 70). Consequently we may then say that “we are not all able to see, hear, feel, speak and move about independently” without a proper cultural framework (Shilling 1997: 23).

As a consequence, as Crossely argues, “our embodiment is our point of view on the world...” which means that it “locates us in the world, putting us in a spatio-temporal relation with other beings and giving us a standpoint, literally, from which to perceive them” (2007: 82). While this definition can at first glance suffice, the body does reflect more than our spatio-temporal relations. The body has also the added ability to reflect us and who we are: our social and cultural identities. We can almost say that within the body there resides another person, another being. This is not the being of organs that to use Leder’s expression typically dys-appears:

my body is not merely the perceptible material that you can see, smell and touch, nor even the internal organs that medical science can measure, with and monitor. It has another ‘inside’ that surgeons and neuroscientists cannot access; an inside comprising lived sensations which form the coherent and meaningful gestalt structures that are my consciousness of the world (Crossely 2007: 82)

An understanding of the body as a source of meaning has been usefully explored by Erving Goffman and it is to a discussion of his work that we now turn to.

Erving Goffman: Body as Agency

Goffman's approach to understanding the body is clearly outlined in three main ideas: the body is the "a material property of individuals" (Shilling 1997: 82); it is the locus of "shared vocabularies of body idiom", and lastly it is the mediator between individuals' multiple social identities (Shilling 1997: 82). Goffman's approach is quite different from the naturalistic approach to understanding the body. While the naturalistic approach views the body strictly as a biological entity (literally commandeered by biological needs), Goffman readily separates the body from the individual. Not denying the body its biological attributes, he does, however, infuse the body with a socio-cultural framework. In this, Goffman "is centrally interested in how the body enables people to intervene in, and make a difference to, the flow of daily life" as he associates the body with agency, and more specifically how the body "requires and enables people to manage their movements and appearances" (Shilling 1997: 82). This does not happen in a social void, rather society has established a set of norms and regulations that are in most cases felt and rarely expressed through language, something like Mauss' 'techniques of the body'.

Goffman conceptualizes these norms and regulations in terms of "shared vocabularies of body idiom" (Shilling 1997: 82). While these vocabularies are socially constructed, they are not entirely under the "immediate control of individuals" because they are socialized non-verbal actions that have come to bear meaning within a specific social setting (Shilling 1997: 82). For Goffman, these vocabularies refer to such things as "dress, bearing, movements and positions, sound level, physical gestures such as waving or saluting, facial decorations, and

broad emotional expressions” (Shilling 1997: 82). All these non-verbal gestures readily inform other individuals who know the idiom of information such as age, gender, social status, economic status etc. According to Goffman, these classifications strongly influence how individuals attempt to manage their bodies (Shilling 1997: 82). Thus, the body is not just a static element but a dynamic representation of the individual within a precise social and complex setting. Bodies are not just physical entities that allow us to move in the world. Through the body, individuals can represent and express themselves non-verbally through socialized bodily expressions. In essence then, the body is a social code that can, depending on where the individual is socialized and how the individual uses his or her body or is seen through his body, capture and send social signals that relate our feelings, emotions, attitudes, and beliefs. In *Stigma*, Goffman writes that “society establishes the means of categorizing persons and the complement of attributes felt to be ordinary and natural for members of each of these categories” (1965: 2). This means that “social settings establish the categories of persons likely to be encountered there” (Goffman 1965: 2). Because of this social categorization and the intended social expectations, “the routines of social intercourse in established settings allow us to deal with the anticipated other without special attention or thought” because the social expectation has been met (Goffman 1965: 2)

As we mentioned above, Goffman also argued that the body functions as a mediator in the relationship between “people’s self identity and their social identity” (Shilling 1997: 83). In this sense, individual appropriate these social constructs by internalizing them as their own bodily gestures. Thus, an individual while maintaining a social identity also internalizes these bodily performances as his or her individual identity. In other words, an individual’s self-identity becomes a social footprint of society. In this case, it becomes clear to the individual that society expects these socialized performances. Thus, if by chance an

individual is incapable of meeting these socio-cultural expectations due to chronic illness, disability or S.U.P, then these socio-body performances will obstruct an individual's participation in wider socio-cultural processes. Goffman writes that a person "possessing an attribute that makes him different from others in the category of persons available for him to be... is thus reduced in our minds from a whole and usual person to a tainted, discounted one" (1965: 3). And in this process, his or her self-identity is made fragile. Moreover, Goffman asserts that "the vocabularies of body idiom" are not only used to classify others, they are also used as grids of *self-classification*. If a person's ability to manage their bodies and hence their appearance is not appropriate then they are read by others as failed members. If this happens with sufficient frequency then individuals will internalize the label and see themselves as having "spoiled self-identities" (Shilling 1997: 85). Supporting Goffman's argument about the body as the mirror for socio-cultural reflection, Pierre Bourdieu emphasized the "multiple commodification of the body" (Shilling 1997: 186). He argues that "social systems incorporate within them a variety of social fields which attach values to different types of bodies. In these conditions, there is a tendency for people's self-identity to become increasingly tied to their bodies" (Bourdieu in Shilling 1997: 186).

Furthermore, individuals utilize the body to fulfill multiple functions and roles like "the concerned mother, the angry teacher, the sympathetic social worker" (Shilling 1997: 83). The body, through the performance of more than one role enters multiple relations that can become a significant indicator of gender inequalities and power relations. Goffman argues that "men often treat women as faulted actors with respect to normal capacity for various forms of physical exertion" (Shilling 1997: 84). Building on Goffman's argument, Susan Bartky argues that a man "may literally steer a woman everywhere she goes: down the street,

around the corners, into elevators, through doorways, into her chair at dinner table” (Shilling 1997: 84).

Goffman has also analyzed two important aspects of the relationship between the body, pain, and identity, i.e. ‘embarrassment’ and ‘stigma,’ that have an important bearing on our research as we pointed to earlier. According to Goffman, embarrassment is specifically caused “when people display inconsistencies in their character (when they fail to enact their social roles with poise), or when individuals fail to maintain the smooth flow of interaction (when the rules governing encounters are broken)” (Shilling 1997: 86). But this embarrassment occurs through the agency of the body. Many of these failures are specifically related to the body because individuals within a social setting expect certain roles to be communicated properly in a bodily idiom. In the case where these are not accomplished, the individual will right away feel shy, or blush, or will seek to quickly rectify the situation. Goffman asserts that ‘embarrassment’ does not typically change or affect the person’s self-identity; society will exert itself through its demand for bodily compliance. Thus any deviance will be readily felt and quickly corrected by the individual. In other words, through bodily activities, the individual is kept aware of his actions and of what society expects from him or her.

‘Embarrassment’ can “signify a threat to a person’s social identity and his or her self-identity as a full and competent member of society” insofar “as it reveals a gap between what Goffman terms their *virtual social identity* and their *actual social identity*” (Shilling 1997: 86). ‘Virtual social identity’ refers to the generic attributes that are associated with specific forms of social interaction, categories and social roles, while ‘actual social identity’ refers to how the actual attributes that a given individual possesses: “virtual social identities tend to be governed by a general desire to present ourselves as ‘normal’ people worthy of

playing a full part in society” (Shilling 1997: 86). However, over time, these two identities can exhibit some contradictory qualities as our actual identity and capacities “impinges” upon our virtual identity. When “gaps” become apparent, it will “lead to occasional episodes of embarrassment”; however, as we mentioned above these episodes tend to be reparable.

According to Goffman, there are also many cases where individuals who do not uphold their virtual identity (due to some severe cause like a chronic illness or disability) tend to get “stigmatized,” which specifically refers to “attributes that have been labeled as deeply discrediting” (Shilling 1997: 86). Goffman elaborates on the definition of ‘stigma’ in two forms. He first says that stigma “will be used to refer to an attribute that is deeply discrediting,” and that ‘stigma’ can be split into three separate types of which the first one is the most relevant to this discussion and that is the “abominations of the body – various physical deformities” (1965: 3-4). Not surprisingly, stigmatized individuals have many problems in social settings that separate them from ‘normals’ and this can impact individuals’ self-identities very negatively (Shilling 1997: 86). And if they try to pass as ‘normals’, it is even more “discrediting” when a major visible difference (through a body idiom) once again appears between their virtual and actual social identity. In other words, in these cases, Goffman writes that the “stigmatized individual tends to hold the same beliefs about identity that we do...” (1965: 7). And therefore, the standards that s/he has incorporated within them from society leave them “intimately alive to what others see as his ‘failing’, inevitably causing him... to agree that he does indeed fall short of what he really ought to be” (Goffman 1965: 7).

The stigmatization of individuals due to their inability to perform their social obligations and hence the loss of their virtual social identity causes their real and actual identity to appear. Goffman continues that “a discrepancy may exist between an individual’s virtual and

social identity. This discrepancy, when known about or apparent, spoils his [sic] social identity; it has the effect of cutting him off from society and from himself so that he stands a discredited person facing an unaccepting world” (1965: 19). And because their identity does not match the social construction, they are socially rejected and pushed into increased social alienation and isolation, or they can simply accept their situation through an ‘identity trade-off’ (Charmaz 1995). Shilling writes that “Goffman’s analysis of stigma displays a particular interest in the problems of the disabled because of the amount of work they have to do in order to be accepted as full members of society” (Shilling 1997: 87). But this does not only apply to disabled persons. His theory could be applied to individuals that undergo severe chronic illness and pain or those who are undergoing any form of S.U.P. Hence, the chronically sick and severely disabled individuals that carry visible markers on their body in society are the most prone to suffer socially through the loss of identity because the body is the medium in which identity through social interaction is built. Thus “Goffman’s analysis of stigma is relevant as it suggests that an individual’s sense of self is likely to be affected by judgments made about the worth of their body” (Shilling 1997: 186).

Body, Self, and Identity Dilemmas: an Individual Experience

Talking about the effects of impairment on the sense of self and identity of the individual, Kathy Charmaz, in her study on individuals adapting to impairment, writes that “chronic illness intrudes upon a person’s daily life and undermines self and identity” precisely because this chronic pain weakens, challenges and negates valued images of the body (1995: 657). In outlining this argument, Charmaz’s point of departure is, citing Gadow, that essentially human existence “means embodiment and that the self is inseparable from the body” (Gadow in Charmaz 1995: 659). But for Charmaz and Gadow, inseparability does not

mean that the self and the body are “identical”; rather they are both unique in that the body heavily shapes the self through various social interactions. In the context of impairment, Charmaz explains that “the relation between body and self becomes particularly problematic for those chronically ill people who realize that they have suffered lasting bodily losses” (Charmaz 1995: 659). Those who suffer any form of chronic pain, body loss or impairment, lose an ability to communicate some aspects of their selves. They become outcast insofar as they are unable to fully function as social beings, yet also unable to fully pull away as they are dependent on social interaction in their daily lives. Victor Kestenbaum (1982) argues that “illness threatens a person’s sense of integrity of self and the body and the self and the world. People who have serious chronic illnesses find progressive losses repeatedly threaten their body and self integrity” (Kestenbaum in Charmaz 1995: 660). With the progressive loss of their virtual social identity, it becomes evident that “identity questions and identity changes can emerge and occur” (Charmaz 1995: 660). In this case, identity becomes the crucial yardstick to determine one’s social position and confidence. If identity problems are not quickly rectified, these problems can be potentially transformed into more serious problems such as suicide, alienation, and isolation, as one feels the impingement of “stigma” and “embarrassment”.

In relating their painful experience to Charmaz, individuals undergoing chronic illness and pain have noted increased “physical changes” and “diminished bodily functions” (Charmaz 1995: 662). A forty-one year old woman described her experience with chronic pain and illness (from severe asthma) in the following way: she felt as if her body “betrayed” her and that the body has become “foreign territory” or that “it was not the body I knew” (Charmaz 1995: 662). And according to social scientists (Goffman 1963; Shilling 1997; Charmaz 1983, 1994, 1995; Blumstein 1975) these feelings of betrayal, alienation, and

estrangement from the body are a result of individuals becoming aware of losing control over their bodies and the powerlessness of the medical community to help them rectify this situation.

Goffman writes that a woman who lived with one of her daughters used to be an “independent, warm and friendly woman who enjoyed traveling, shopping, and visiting her relatives” before her facial disfigurement (1965: 12). However, after this bodily change, the social stigma was overbearing, resulting in a dramatic transformation of her lifestyle (Goffman 1965: 12). This meant “she seldom left the house” because she felt “heartsick” due to her new appearance, and she felt like “the door had been shut on [her] life” (1965: 12).

Charmaz emphasizes that “the body once viewed as a taken for granted possession to control and master has spun out of control. At best, the body is now a failed machine, an obstacle to be repaired, overcome, or mastered. At worst, it has become a deadly enemy or oppressor” (Charmaz 1995: 662). Another woman suffering from asthma complains that her body is “slowing” her down and that her body is actually in “control” of what she does or where she lives and “who [she] can be around with” (Charmaz 1995: 662).

As one would expect following Goffman, many interviewees with a chronic condition experienced “guilt and shame” and “self-abasement” because they did not meet the required social standards and expectations (Charmaz 1995: 663). Their public and internal “humiliation” made them feel like “failures” or not quite like “whole” persons (Charmaz 1995: 666); they felt unsure of how they would be identified and received by “normals” (Goffman 1965: 13). Others were upset at being themselves, as one woman with mastectomies (after battling breast cancer) said she felt “different” and not “like a woman anymore” (Charmaz 1995: 667). Another woman battling lupus erythematosus hated her body because she complained that “people look at you like something’s wrong” (Charmaz 1995: 667). But for social scientists, these feelings of anger and detachment from the body

are a 'normal' process because a major discrepancy between the virtual and actual social identity has appeared. In this case, individuals are constantly aware of how others treat and observe them. And if one is feeling social pressure to conform but cannot due to a chronic illness, then abhorring the body is a way of distancing the self from the disease. In essence they are screaming to themselves that "Hey it's the same old me inside this body!" (Charmaz 1995: 670-1) In this context, Charmaz sums up this identity crisis that these individuals undergo as follows: "feelings about visible disability influenced identity goals. When men could not hide or minimize their changed appearance [or could not assert their virtual social identity], they often withdrew" which are symptoms of the "stigmatized" individual and "hence their identity goals [i.e. virtual social identity] plummeted" (Charmaz 1995: 667). She continues that "women withdrew less but dwelt upon appearance issues in the interviews much more than men" because they worried more about their self-presentation in the public and social sphere. However, this management of body and appearance takes a heavy toll on the self and identity of individuals because they become overly preoccupied in concealing their social shortcomings, which at times could causes rifts between their virtual and actual identities (Charmaz 1995: 667; Goffman 1965; Shilling 1997).

However Charmaz notes that not all individuals seek solace in seclusion and isolation from the forces of socio-cultural norms and expectations. The effect of chronic pain and illness on the body can either "undermine present identities" or "force lowering identity goals" (Charmaz 1995: 668). This is not associated with a low self esteem as in the case of the 'stigmatized' individual, but is more a form of adaptation to a real and present situation because "identity dilemmas result from losing valued attribute, physical functions, and social roles, and personal pursuits through illness" (Charmaz 1994: 269). Charmaz admits that the lowering of identity goal is not as straight forward as it sounds because there is a sort of

internal “resistance”. Over time, however, holding onto social expectations becomes futile as the bodily illness encroaches on one’s identity and ability to maintain a virtual social identity. In these cases, people will tend to sacrifice either their health to maintain their present identity, but more often than not, they will sacrifice their virtual social identity (and consequently their self-identity) in order to cope with the exacerbating demands of their ill body. Hence, illness and pain, do more than just sheer hurt, they are able to change the individual’s perception about their self and identity, and their social role. Thus, debilitating and chronic pain, and illness can be conceptualized as having the capacity to alter and modify an individual self image and his or her sense of social responsibility. In many of these cases, the individual simply surrenders to the sick body. By surrender, Charmaz means literally to “stop fighting the episode[s] or the entire illness. The quest for control over illness ceases and the flow with the bodily experience increases. Surrender [therefore] means awareness of one’s ill body and a willingness and relief to flow with it” (Charmaz 1995: 672).

Socially and personally, identity goals and dilemmas can have a severe impact on the individual. For example Robert F. Murphy, a noted anthropologist, suffered from an illness termed as ‘progressive paralysis’. Murphy felt incredibly “pressured” to remain in the lead, to publish and command the respect of his colleagues (Charmaz 1995: 670). He personally writes that “my overreach beyond the limits of my body was a way of telling the academic world that I was still alive and doing what I always did” because he felt that if he was to be constrained by his body it would affect not only his social interaction and his personal identity, but more so it would affect his identity as a scholar and an active anthropologist. Another woman complained that in order to feel productive and to keep her virtual social identity, she worked even though she felt immense pain. However, when she could no longer

balance between the social and the private, she gave up her work. She succumbed to the pains of her body (Charmaz 1995: 671).

All authors discussed in this section provide the different components necessary to think about the relationship between pain and social identity. While Williams and Bendelow look at how medicine is limited in dealing and explaining pain, Leder points to the fact that pain and the body is inevitably linked. Pain has the ability to bring back the body to the forefront of social relations. The absent body reemerges, brought forth through the pain that interrupts the daily flow of taken-for-granted activities. Pain and the body do not exist in a social void. Individuals in society are integrated through a variety of different techniques of the body. Consequently, as Goffman and Charmaz both show, pain needs to be interpreted not only as a physical process, but as phenomenon that affects the individual's abilities to maintain identities and to function in everyday life.

Sociology of Religion

Central to Foucault's conception of medicine is the notion that medicine is a product of social relations and thus it "can be seen as a powerful form of regulation, restraint and representation of the body as flesh" and that the body is not just present within socio-cultural relations, but moreover it is present within a gridlock of institutional power (Turner 1992: 19). This, according to Foucault, is "how power operates in modern institutional formations 'through progressively finer channels [known as micro-politics], gaining access to individuals themselves, to their bodies, their gestures and all their daily actions'" (Foucault 1980: 151; Shilling 1997: 75). These 'finer channels' of control are no doubt related to medicine because "medicine is an important part of what Foucault had in mind by the notion of micro-politics, that is forms of political practice which are decentralized and operate

locally through various institutional settings such as the anatomical theatre and the medical clinic” (Turner 1992: 19). This can serve to explain Kleinman’s concern that humans are increasingly seeking “a medical [framework] to cope with [their] distress” (1988: 27).

In addressing these ‘finer channels’ of bodily control, Martin Hewitt, reiterates the Foucauldian example of sexuality in biomedicine as it is presented as “‘scientific-legal discourse’ and practice, in medicine, religion, law and social policy, which affects the workings of the entire social body... even parts that other forms of [traditional] power cannot reach” (1983: 227). But sexuality has deeper social and biomedical implications, it also gives rise to numerous other factors of social and public controls that monitor “birth rate, the age of marriage, the legitimacy of births, the frequency of sexual relations, contraception etc...” (Hewitt 1983: 227). While this type of discursive power and control is without doubt present (especially within the confines of the medical laboratory and clinic), individuals increasingly rely on medicine to help them overcome their lack of control in bodily problems such as chronic illness and pain (Kleinman 1988). Additionally then, this subtle formation of bio-politics and power could also be none other than the need for control that humans seek in order to maintain an ordered reality. Hence, it becomes clear that bio-politics according to Foucault is the “investment of the body with properties making it pliable to new technologies of control...” specifically combined with the “advent of the empirical human sciences, making possible these new technologies of control” (1983: 228). Concerning modern techniques of control, McKenny writes that it is this specific combination of “technological control over nature” and that of a “moral commitment to relieve suffering” which “accounts for a large part of the nature and task of medicine in the modern era” (1997: 19).

Modern medicine, by having “unquestioned commitments to technological control of the body for the sake of eliminating ‘misery and necessity’” is at the core of Foucauldian

bio-power (McKenny 1997: 19). This form of bio-power simply consisted of power “over bodies and by bodies” (Hewitt 1983: 230). According to McKenny, “the body as object of spiritual and moral practices is replaced by the body as object of practices of technological control” and “as a result, medicine is based on practices and techniques of control over the body rather on traditions of wisdom about the body” (1997: 21, 20). This need for mastery and our inherent lack of bodily control only justifies our excessive need for biomedical control. Inevitably, what has been created by humans seems to be at the same time constraining their every effort to escape this biomedical monopoly because “to recast Foucault, medicine was reshaped by placing the sphere of clinical experience within the demands of the laboratory, all of which was later relocated within the sociopolitical requirements of a society that supported health care as being integral to its culture” (Engelhardt 2002: 70).

Therefore, increasingly “the biomedical scientist became an individual able to manipulate nature in order to disclose its secrets” and “in addition the controlled manipulation of nature through well-designed experiments became a further avenue to certifying clinical claims” (Engelhardt 2002: 67-68). Our bodies are indeed also a part of that greater nature that biomedicine intends to control. Henceforth, the emergence of the modern laboratory/clinic could be seen as none other than the attempt to manage and control the body because at the root of every individual’s nature is the lack of the proper and natural mechanisms of control to the vital functions of his or her body. Ironically, however, every individual’s own body seems to function independently without the guidance of the self (Leder 1990; Buytendijk 1962). Ultimately, the body is its own master. But individuals cannot be subservient to the unpredictable nature of the body; individuals need to redevelop their nature and identity by controlling and subduing their own body. In this case, when

biomedical power is at its limits of control and thus fails in some degree to accomplish this specific task, individuals might seek other cultural or religious frameworks as they “also offer a way to deal with the threat of uncertainty and lack of control. Religions speak of a surrender to the divine or God’s will, thus taking the need to control out of our hands as we abandon ourselves to a greater transcendent being or concept” (Puchalski et al 2005: 120).

Fundamentally though, biomedicine is a cultural and scientific means of control over our own bodies; it is the answer to our apparent obsession with control and order. However, when biomedicine falls short from fulfilling this complete control over the body, individuals might seek other means. These other means must once again demystify the body so as to enable individuals to take back the reigns and steer the course of his/her life as s/he pleases. In this case, temporarily substituting biomedical control by a quasi-religious control of the body, even though utilizing different cultural means, seeks to infuse solace into the individual by thematising the return of normality and order from this temporary chaos and confusion. It assures the patient that one must cease worrying because the body is once again at the service of its master. This constant worry, uncertainty, and what seems to be as the lack of control, could act as catalyst for this emotional resurgence and acceptance of a religious and cultural framework that seems to provide the control the biomedicine fails to maintain. Hence the shift from biomedical to religious control could very well be the consequence of biomedicine’s inability to provide a holistic account of pain, illness and disease (Puchalski et al 2005: 115). This assures the individual that this temporary chaos is transitory and a new form of order over the body has been reestablished. This is important not only because spirituality is possibly at the core of our humanity but also in the sense that “[s]pirituality... is something that is found in all cultures. It is the search for ultimate

meaning in life and also the way some people cope with illness, stress, and loss” (Puchalski et al 2005: 115).

Because cultural and religious frameworks can be the source, in fact traditionally have been, the source of meaning, understanding the role of religion in relation to pain is important. Not least because when dealing with chronic and inexplicable pain biomedicine confronts its limits and because “numerous surveys have identified barriers that interfere with adequate pain management ... [they] include inadequate knowledge of pain, poor assessment of pain” (Vrancken 1989: 435; Coyle 2004: 300-1). Additionally, surveys have demonstrated the failure of a variety of medical personal to evaluate or properly gage the severity of pain because pain is only “managed within the framework of the diagnostic activity in which the doctor is engaged” (Coyle 2004: 300-1; Heath 1989: 115). Increasingly, “studies have shown that when faced with chronic medical illness, many persons turn to their spirituality and religious beliefs” (Keefe et al. 2001: 101; Conway 1985; Koenig et al. 1992; Heyse-Moore 1996; Puchalski et al. 2005). In essence, biomedicine’s inability to provide a meaningful medical/scientific answer or a cultural framework for those specific pain episodes opens up individuals to seeking out other forms of cultural resources such as religion, to provide meaning and answers even though these religiously associated meanings and answers can be considered beyond the scope of rationality.

The sociology of religion is a broad field that cannot be easily summarized. For the purpose of this research, we are particularly interested in approaches to the sociology of religion that highlight how different religious systems provide a soteriology, that is to say a vision of the world which expresses how individuals might achieve salvation, Weber argues that “the various ethical colorations of the teachings of god and sin stand in the most intimate relationship to the striving for “salvation”” (Weber 1969). A soteriological vision, then, as

Weber argued, gives answers and explanation for the oft-repeated questions about life, creation, and humanity's objective. In Weber's account of salvation and human conduct,

[t]he quest for salvation acquires a positive and this-worldly orientation most strongly through the creation of religiously determined "conduct of life", which is integrated into a central meaning or a positive goal and which has the strongest chance of exerting practical influences when there has arisen, out of religious motivations, a systematization of practical actions formed from an orientation to certain unified values (Weber 1969).

Religion then, seems to provide a possible cultural answer to pain related questions by organizing our daily behaviour and by asserting that life and creation (and thus pain) have a higher end, thus assisting people to cope with fears about chaos and randomness. According to J. Milton, "the manifest function [i.e. purpose] of religion is to provide an objective in life and to give meaning to such events as death, pain, and injustice, and to whatever is evil within existence" (Cipriani 2000: 155).

In addition to this, as Durkheim was to argue, religion can also be understood in terms of its social functions (Bellah 1973). In other words, religion can promote social cohesion and solidarity. This social cohesion and solidarity originate from the social rituals and cultural practices that are regulated within society to strengthen social identity by reinforcing existing identities so as to maintain group solidarity. This means that religious behaviour becomes the vehicle of reinforcement, thus that we must look at "religion as a part of a cultural system or to use Geertz's formulation to a "historically transmitted pattern of

meanings embodied in symbols, a system of inherited conceptions expressed in symbolic forms” (Hamilton 2001: 177).

What this specifically provides is the vision of a general atmosphere of order in a world otherwise subject to chaos and disorder. This idea is well captured in the work of Malcolm Hamilton, on the *Sociology of Religion*, expanding on Clifford Geertz’s idea of *Religion and Meaning*, he says that “religion does this [provide a sense of order] by formulating concepts of a general order of existence. People need such concepts. They need to see the world as meaningful and ordered” (Hamilton 2001: 178). However as Geertz was to point out three forms of experience threatened to undermine this sense of order: bafflement, suffering and evil” (Hamilton 2001: 178).

Religion also provides a source of containment and risk management within society. It provides followers security through the attachment and bonds they form amongst themselves, which nurture feelings of care and reciprocity. Thus religious behaviour not only serves to locate individuals in the world, but “part of what religions do is give us a picture of how we fit in with our community, with family, with the larger human experience, and the transcendent element in our experience” (Puchalski et al. 2005: 115). Chris Shilling, in attempting to explain the meaning-system religion provides, notes that “[i]rrespective of modern technological advances, death [and illness and pain] remains a biological inevitability which is ultimately outside of human control” (1997: 175). And because individuals are not by themselves able to explain these biological inevitabilities (in this case such as chronic illness or S.U.P), religion then becomes a possible framework through which individuals try to understand themselves and their bodies. It is then for this reason that Shilling continues that “the argument here is that humans are a species whose very conditions of embodiment force them to act and to invest themselves and their actions with

meaning, in order to survive” and (1997: 176), therefore, “the prospect of death [and of illness and pain] constitutes a threat to people’s ‘world-building’ activities which needs to be dealt with by society through the provision of shared meaning systems” (1997: 176). But he notes, that “[t]he provision of such systems has become increasingly problematic in modernity, especially in the context of the shrinkage of space occupied by religion” which in traditional cultural settings has provided a ‘stable sense of identity’” (Shilling 1997: 176). In this respect, Shilling reminds us that most broadly, it has been religion that has provided individuals with the “sacred canopy” under which they have elaborated a shared vision of the world, the body and identity (1997: 178).

Whether a certain religion is right or wrong is not our concern here but what we are looking at is the symbolic role of religions, the way in which religious experience can serve to infuse meaning to questions about pain, illness, and humanity within a community. This creation of the symbolic universe helps integrate meaning and creates a strong symbolic relation between humans and their lives because “symbolic universes are systems of meaning by which everyday life is brought into relation with a transcendent reality” (Hamilton 2001: 184). This creation of the symbolic universe is not by choice but by a natural compulsion to give meaning to an otherwise mysterious world because “men [sic] are congenitally compelled to impose a meaningful order upon reality” (Hamilton 2001: 181).

Therefore, when it comes to complex issues such as ‘*why do humans go through pain and suffering?*, or *why me?*, or *why do we suffer?*’ religion can provide a possible meaningful answer. It does not provide a simple cause and effect explanation like biomedicine’s physiological attempts; it gives a symbolically more complex answer that invokes the order of the cosmos and the mystery that veil it. Consequently, pain and suffering become elucidated through a metaphysical worldview in which individuals are integrated into higher

and typically divine logic. This has two implicit meanings, one which is that nothing happens without a meaning, and the other that whatever happens is not outside the sphere of rationality and understanding, but within its realm (this could be a test or punishment caused by the actions of the individual). These two implicit meanings rest on the basis of a higher meaning, and a higher justice which turns pain and suffering into a dignified element or an element of reverence (such as the Christian notion of the 'suffering self'). Thus religion "attempts to cope with suffering by placing it in a meaningful context, by providing modes of action through which it can be expressed and thus understood. To be able to understand it is to be able to accept it and endure it" (Hamilton 2001: 179).

Religion and Pain

While most visible diseases of the body require medical treatment, pain in its multitude of sensations and as a lived experience cannot be explained through just the use of medical diagnosis as we have seen above. Actually in many cases, medicine is incapable of alleviating or at the least explaining pain (and subsequently it has shifted incredible resources and focus on palliative care). Moreover, as Bendelow and Williams argue, it is frequently the case that

the location of pain may be different from the location of damage; pain may persist in the absence of injury after healing; the nature and location of pain changes with time and there is no adequate treatment of certain types of pain, especially idiopathic pains in which there is no sign of tissue damage and no agreed cause (1995: 142).

So if pain cannot be accounted for through material-physiological causes alone then an adequate explanation must draw on other cultural paradigms.

Life in a modern society tends to separate people from the inevitability of death and the body. According to Shilling, “death can threaten the basic assumptions upon which society is organized, as well as open up the individual to the dread of personal ‘meaninglessness’. Death radically questions the taken for granted, ‘business as usual’ attitude which is usually adopted in everyday life” (1997: 179). And because those who have a severe illness “may know rationally that death [due to their illness] is imminent” (Heyse-Moore 1996: 306), they might seek a cultural paradigm to explain their immediate situation. Shilling adds that not only does religion “appear to the individual as an immensely powerful reality which locates life in an ultimately meaningful order” but “religion even allows for the possibility of having a ‘good death’, that is a death in which the individual retains to the end a sense of the meaningfulness of their body, their self-identity and the social world” (1997: 179). This ideological thinking might seem useless at first glance, however, it does change an individual’s attitude towards pain and illness and his/her self-identity. The experience of pain does not only raise questions of mechanical causality, but also broader questions that include “why me? Why now? Why do good people suffer? Did I do something wrong with my life? Am I praying hard enough? Maybe I have not been a good person? What give my life meaning and purpose” (Pulchalski et al. 2005: 115). Thus Bendelow and Williams write that “pain is open to a variety of interpretations and meanings which go far beyond the sheer hurt of its original presencing” (1995: 154). This is because we may “experience pain as a constriction of our essential possibilities and come face to face with our vulnerability, finitude and the untimely nature of our death” (Bendelow and Williams 1995: 154).

However, it then becomes manifest to some individuals in pain that there is some sort of force beyond their grasp that has a sort of hand in their affairs (i.e. their painful experience). At that moment individuals can come to terms with their new reality, that within this painful experience all causes within this world come to an end and a new reality within the individual emerges. This reality is that humans simply sense the existence of something beyond their control almost “[a]s the very sensation of something wrong, or bad, pain may be identified with moral evil, the result of an external, malignant force, or as a punishment for our sins” or simply a test (Bendelow and Williams 1995: 154).

This spiritual self-blame or inquiry does not just arise in the context of an explicit religious standpoint, but simply sprouts out of individuals who feel that their life and destiny within this painful experience of suffering lies beyond their grasp and reach. Shilling elaborates that “religion or ‘the establishment, through human activity, of all-embracing sacred order’, has a particular role to play in providing and sustaining such legitimations. Religion legitimates the world-building activities of people because the cosmos posited by religion both transcends and includes the individual” (1997: 178). It is at this point that individuals simply turn to a religious or quasi-religious explanation. As Bendelow and Williams argue, “these explanations for suffering may be linked to deeply entrenched religious or spiritual beliefs, even if an individual does not follow any particular faith, and punishment and self-blame are common themes” (1995: 154).

These religious or quasi-religious justifications that can emerge in the context of unexpected pain (or S.U.P) seem irrational from a medical or scientific perspective because medicine and religion are to some extent culturally incommensurable. In this context, Durkheim notes in *The Elementary Forms of the Religious Life* that “that which science refuses to grant to religion is not its right to exist, but its right to dogmatize upon the nature

of things and the special competence which it claims for itself for knowing man and the world” (Durkheim in Bellah 1973: 205). However, in many ways, individuals experiencing severe forms of chronic pain tend to combine the cultural world of medicine and religion. On the one hand, individuals seek medical treatment for some of these chronic pains (at least for those which are recognized by medicine) and at the same time integrate a religious or quasi-religious and cultural explanations to cope with their pain and illness all the while at the same time, these individuals attempt to attribute meaning to their chronic suffering and pain.

So then the question is why are pain and religion so intertwined? And, what is the link between them? Let us quickly describe pain in order to make the link. Pain as a universal feeling can be characteristically unexplained, unexpected, sudden, and incomprehensible by logic and reason insofar as it interrupts the logic and reason that oils the functioning of everyday life. What it creates within an individual is usually a feeling of bafflement, fear, anger, despair, weakness, finitude, vulnerability, and alienation. Religion certainly provides possible answers to these experiences in time of crisis where a person will grasp out for an ideology of comfort, or as Shilling says, a ‘sacred canopy’ (1997: 178). Religion, then, not only offers answers to these questions, but also provides solace through crisis management and through an enhanced system of meaning and reorganization of identity. In other words, “religion does not simply legitimate and make sense of the social order. It makes sense of experiences which might otherwise be disruptive and disordering” (Hamilton 2001: 182).

Sudden, unexpected, acute, prolonged and debilitating pain has the tendency to shatter our social construction of the world, our social reality and identity. Kathy Charmaz adds that “the suddenness of illness, its intensity, and timing in the life course pose special identity dilemmas” (1994: 269). It changes and modifies our immediate (and potentially long

term) experience. It can function as a shock of such intensity that it is able to shake the very foundation of our immediate existence. Charmaz, in analyzing the relationship among the body, identity and self, writes that “chronic illness assaults the body and threatens the integrity of self. Having a serious chronic illness shakes earlier taken-for-granted assumptions about possessing a smoothly functioning body. It also disturbs a person’s previous assumptions about the relation between body and self and disrupts a sense of wholeness of body and self” (1995: 657). It is only because of its severity in our lives (and its inexplicability) that we turn to find answers to this effect. We turn for answers, not any answer but an ultimate answer for this shockwave of experience. Hamilton drawing on the work of Geertz says that “bafflement is the experience which comes about when unusual or dramatic events occur, with which none of the normal means of explanation are competent to deal. Religion provides an ultimate answer as it explains the otherwise inexplicable” (Hamilton 2001: 178).

Another relation between pain and religion is the fact that humans live within a socially constructed society. And within this socially constructed society, they seek and attempt to live meaningfully. Culturally, an individual’s socially constructed reality compels him or her to associate cultural meaning to events because as Shilling asserts “humans are a meaning-seeking species incapable of sustaining a stable existence apart from the nomic constructions of society” (Berger in Shilling 1997:180). So then, when individuals are placed (or forced) into situations where a medical meaning is not readily available or discerned, they opt for other cultural frameworks, even if these new frameworks go well beyond any rational or a sensible-reality. However, this quest for individual meanings for specific events could very well provide a link between the body and this constructed social reality: in the absence

of any immediate meaningful medical solution to deal with social or medical uncertainties, religion as another cultural framework can become the matrix of meaning.

Furthermore, because individuals are unable to remain in a meaningless social vacuum, they proceed to adopt a cultural meaning that translates their situation into one of meaning because religion “has traditionally provided a potent source of self-identity enabling individuals to locate themselves and their bodies within trans-personal meaning structures” (Shilling 1997: 179). It is not surprising that it should reappear in times of crisis. Thus, religion has the potential to bring back order and some sense of normalness to this immediate experience. It also helps bring back an identity goal and facilitates the transition to an alter identity allowing individuals to redefine themselves as they attempt to merge their experience with meaning (Charmaz 1995). Religious experience then should be understood as a cultural force capable of restructuring identities and selves so as to infuse them with meaning, a meaning that will bind the individual with the sacred, with an ultimate cause.

Not all incidents of pain produce the types of shifts in identities and provoke a search for meaning as described above. However, if pain is severe, unexplained, prolonged, and disruptive of the daily routines and identities that anchor social identity (i.e. chronic or S.U.P), the gravity of the situation might force the individual to ask questions in the form of ‘Why me? What did I do?’ In this case, ‘meaningfulness’ and ‘meaning-seeking’ is attributed and directly related to the intensity and gravity of the situation. Thus, a pain becoming ‘meaningful’ depends on the gravity, suddenness, intensity and disruptive of the condition. Consequently, it is no surprise that Keefe et al. note that “studies show higher levels of religious coping in the face of more serious, more stressful negative life events” (2001:102). Additionally, they have found evidence that suggests that the “efficacy of coping” is related to the ability to control a situation (2001: 102). In other words, the underlying assumption

here is that the incremental severity of pain is directly proportional to the increased attempt to attribute some type of 'meaningfulness' to it.

As we have seen above, biomedicine has been incapable of providing meaningful explanations to those who suffer from chronic pains and for the experience of pain more generally. Sociology and anthropology have made important contributions in terms of defining pain more broadly. Sociologists and anthropologists have shown that that individuals try to inscribe pain in a meaningful context. If biomedicine fails, they will go elsewhere. We have also seen that religion is powerfully equipped in these contexts to provide a sense of meaning by inserting an individual in an orderly and meaningful world.

At this point, we have finished discussing both the historical background on pain as well as attempts by sociology and anthropology to broaden our understanding of the phenomenon. We have also seen some of the cultural reasons why religion remains an important worldview for dealing with pain. In the next section we will draw on this work in order to develop the theoretical framework that generated our interview questions and the analysis of the interview data.

Chapter Three: Theoretical framework

The major conceptual elements of the theoretical framework for this thesis are 1) a multidimensional concept of pain, 2) the phenomenological experience of the body in pain, 3) the ability that pain has to interrupt socially significant bodily practices that underpin identities, and 4) religion as a cultural system capable of inscribing the experience of pain alongside biomedicine or when biomedicine fails. Pain as has been persuasively argued by many social scientists (Morris 1991; Bendelow and Williams 1995; Kleinman 1988; Hahn and Kleinman 1983,) cannot be understood only as physical or psychological ailment (as suggested by biomedical sciences). It entails a cultural element inseparable from the experience of individuals and how they are positioned socially and culturally. The materialist and mechanical conception of pain with which biomedicine functions is limited in its ability to provide a proper account of pain, and is completely incapable to explain pain when biomedicine is unable to identify a specific cause, as is often the case with S.U.P. As we saw in our literature review, social scientists have been able to make significant progress not only in terms of criticizing biomedicine, but also in terms of developing research that helps us understand the link between pain, body, identity, and religion.

In order to fully understand pain, social scientists have highlighted the cultural aspects and in this way have contributed to the development of a multidimensional framework. Particularly important in terms of developing this multidimensional approach have been the numerous case studies of groups and of individuals in pain. This research shows that pain is subject to cultural variation but also that culture is an important aspect because it enables individuals to give meaning to their experience and helps them define and understand their pain (Morris 1991; Bendelow and Williams 1995; Kleinman 1988; Hahn and

Kleinman 1983). In the case of severe, acute, and chronic pain, characteristic of S.U.P pain, pain has a tendency not only to affect our body but also how we see ourselves because the body in this case becomes the scene or the medium by which we see ourselves and react in the social world. According to Schilling (2001), Goffman (1965), Leder (1990), and Charmaz (1983, 1994, 1995), the body is an important social element that helps us navigate and understand corresponding social vocabularies of body idiom. Thus the body is not only a convenient carrier of the individual and the social self; it incorporates within it a whole social system of learning and understanding. Because of these multiple roles of the body and the various body vocabularies which are aligned within a socio-cultural system, the body is representative of who an individual is, how they are seen by others and how they see themselves. In this sense, acute and prolonged pain comes as a force that is able to break that nurtured relationship between the body and the individual; it becomes a significant obstacle that challenges the ability of individuals who experience it to represent themselves in a social environment. Unsurprisingly, Leder argues that the body is socially not present until a medical mishap appears. This means that individuals take for granted the body and the body literally goes unnoticed until something disturbs its social patterns and its ability to reproduce all manner of social norms or body vocabularies. Leder argues that pain has the tendency to resurrect the body, or make it reappear. In this way, pain does not only hurt (in the biomedical physical sense), it has the tendency to bring forth many cultural aspects associated with it.

Because the body is an important factor as a cultural and social carrier, negative consequences can ensue when the body is heavily affected by pain. Charmaz and Goffman assert that because there is an intricate relationship between the body and the individual, in most cases, what happens to the body, happens to individual themselves. This means that

whatever is caused to the physical body and subsequently to the individual by a S.U.P pain, will translate directly to both the ability of the individual to control his or her body as well as the identity of the individual because identity of individuals is interlocked and intertwined with the social body (McGuire 1990; Hewitt 1983; McKenny 1997). Thus if the body becomes a burden, this has the potential to alter an individual's self conception of who they are. Other than losing vital control over specific and crucial parts of their body, an altered or challenged identity is problematic. According to Bakan (in Leder 1990), a body in pain that forces identity questions, and thus causes internal disorder and chaos will only exacerbate these identity problems especially when pain is both acute and chronic. Moreover, according to Goffman, these identity questions usually stir other issues such as social embarrassment, and in many cases 'stigma'. Charmaz through her extensive interviews documented the same feelings as described by Goffman, and both social scientists claimed that in case of S.U.P pain, individuals will tend to lower identity goals (adapting), or they will seek a path of isolation.

However, because acute pain has the tendency to shatter the lives and the connection of the individual to the social world, in most cases as attested by many social scientists (Bendelow and Williams 1995; Keefe et al. 2001; Conway 1985; Koenig et al. 1992; Heyse-Moore 1996; Puchalski et al. 2005), individuals need to frame pain in a meaningful cultural context. This framing of pain tends to alleviate and lessen the effect of pain on the individual and serves to wrest chaos and bring back control to the affected individual. As noted by Bendelow and Williams, people tend to express these meanings through cultural and religious terms even if these individuals do not affiliate themselves with any religion. In other words, as argued by Geertz (in Schilling 1997), Hamilton (2001), and Shilling, religion tends to act as a 'sacred canopy,' which provides individuals with reassurances in their

situation. Thus it is able to rectify their situations and able to infuse meaning and bring back some form of normative order. Thus, religion here serves to defuse a crisis and bring solace and comfort to the individual, the body, and identity.

This framing of experience within a cultural religious framework is also a sort of temporary substitute for biomedicine as biomedicine in most cases of S.U.P. pain is unable to give an adequate explanation let alone to frame it within a meaningful context. As we saw in our literature review, social scientists such as Kleinman, Hahn, and Bendelow and Williams, all claim that medicine is unable to adequately frame pain except than through a materialist framework. Due to biomedicine's incapacity to address pain beyond a materialist and mechanical conception, as Bakan and Puchalski argue, individuals seek deeper meanings elsewhere. Religion as we saw in our review of the sociology of religion has the capacity to connote a sense of order and meaning, and is therefore available to play a role when all biomedical explanation fails, if only to simply reassure the individual. Religions in this sense help individuals cope with their pain, and understand their situation by an outright acceptance of their situation. Religion is also able to reframe the identity questions that emerge as a result of an individual's incapacity to perform the bodily practices associated with social identities. Religion does this by binding individuals with the sacred, which inherently provides a profound sense of order and meaning.

Note that the usage of the word 'religion' and not explicitly Islam, especially in the theoretical framework is in accord with the work of the researchers reviewed in the previous chapter and the more general features of religion as a cultural system that was discussed in the literature review. These social scientists (Bendelow and Williams 1995; Keefe et al. 2001; Conway 1985; Koenig et al. 1992; Heyse-Moore 1996; Puchalski et al. 2005) did not develop their argument in the context of any specific religion. They did however note that

individuals in the case of S.U.P. pain tended to look for cultural/religious or quasi-religious explanations regardless of whether they were affiliated with a religion or not. So in some ways, it does not matter which religion an individual possesses, what matters is that he or she attempts to attach him or herself to a religious or quasi-religious meaning system. In chapter five, when we deal with the Islam/Islamic worldview, we will tease out the details specific to this religion as this study's main concern is to explore to what extent contemporary Islamic practices contribute to individuals' framing, experience, and understanding of pain.

In summary, our approach understands pain not merely in the biomedical sense, but as a broader individual, social and cultural experience. For the individual, the experience of S.U.P. pain is one of interruption where individuals become aware of their bodies. They experience their bodies as dysfunctional because they are perceived to be out of control and incapable of doing what they could do before. In other words, it is no longer possible for them to take their bodies for granted. The body appears, but as an obstacle and a foreign entity. However, the dysfunction of the body is also socially significant because our identities are tied to our bodies' abilities to perform certain social routines, or vocabularies of the body idiom. A prolonged inability to perform body routines and practices puts in jeopardy our ability to present ourselves to others as certain types of individuals, ultimately having the potential to undermine identities. The interruptions that S.U.P. causes in terms of the phenomenological and social experience of the body also provoke broader questions of meaning: Why me? Why now? Biomedicine with its focus on the material pathways of pain is not equipped to address these questions, thus S.U.P. also has the tendency to create religious or quasi-religious cultural experience. These then are the dimensions that will be used to frame and analyse the qualitative data of this study.

Chapter Four: Methodology

In order to further our understanding of the relationship between pain, identity, the body, and religious experience, this research collected qualitative data with respondents, chosen on select criterion to participate in a semi-standardized interviews (Berg 2004: 80). Berg's definition of a semi-standardized interview falls between a standardized and an unstandardized interview. The former is highly structured and consists of an organized set of questions from which there is no deviation and no adjustments to words or language. In the latter, it is completely the opposite case. It is an interview absent of structure and order where the interviewees (and interviewer) are at ease to pursue issues and themes as they emerge. The semi-standardized interview falls within the two. Its particular utility is that it retains a number of general questions and probes that provide consistency across the interviews, while also allowing respondents a considerable amount of freedom in terms of how they approach and decide to respond to the interview questions. This is particularly suited for enabling respondents to address the types of questions described below with which this research is concerned. Moreover, individual are preferred over group interviews because it was felt that the latter might silence some and primarily because this deals with personal issues where privacy becomes a priority.

An ethics certificate (see appendix) was applied for and obtained from the University of Ottawa Research Ethics Board. Interview respondents were all legally competent English-speaking participants (no minors or children participated in this research). They were reached through poster advertisements in centers of worship (mosques). The respondents, except for the Islamic scholars, had all experienced (or were experiencing) an episode of sudden, unexplained, and prolonged physical pain to be eligible.

The composition is as follows:

- 4 Ulema (or Islamic scholars).
- 8 Muslims who have experienced sudden, unexplained, and prolonged physical pain.

The break down was quite important for the analysis since we were able to explore the more theoretical, formalised, and rationalised doctrinal accounts of Muslim scholars (Ulema), as they explicitly interpreted pain through a religious worldview (or understanding). We were then able to contrast this with the more lived reality of pain of the remaining interviewees. This provided a better understanding of the meaning attributed to sudden, unexplained, and prolonged physical pain from a religious point of view and an individual standpoint. In the interviews with Islamic scholars, questions focused on an Islamic understanding of pain. In addition, the topics of religion and pain, soteriology and pain, medicine and pain, identity and pain (including identity trade-offs), body and pain (embodiment) were also explored. In the interviews with respondents who experienced S.U.P., respondents were asked to speak about their lived reality before pain, in order to allow us to explore to what extent their identities changed as a result of their experience of pain. The purpose of the interview was to elicit major themes in order to analyze some of the dynamics of this mutual shaping of pain, body and identity.

Questions for religious scholars (Ulema) centered on four main topics notably (see appendix I):

- A) meaning of life/purpose of humans
- B) their personal feelings about pain
- C) their knowledge about pain and Islam (precisely how Islam views pain).
- D) their knowledge about the relation between pain and the body

Questions for the respondents who experienced S.U.P. focused on five dimensions (see appendix II):

- A) pain as lived reality
- B) their lives before pain
- C) their lives after pain
- D) the consequences of pain
- E) making sense of pain

In this research we have been developing a theoretical framework that would allow us to explore the relationship between an Islamic worldview/interpretation and the experience of pain. We have already presented the theoretical framework, now it is important to identify some of the most important dimensions of the Shia Muslim worldview as it is related to pain. In the next chapter, we will first provide a broad outline of how Islam positions an individual in the world and in his or her community. We will then summarize the themes and responses provided by the Islamic scholars. The broad overview and the responses from the Muslim scholars will help me to analyze the accounts of pain provided by my respondents. In other words, it will permit me to get a clearer picture of how my Muslim respondents culturally and socially organize their experience of S.U.P.

In trying to understand the cultural significance and lived experience of pain for Shia Muslims, it was imperative to ask them about their feelings and thoughts on pain and about their specific illness. Moreover, it was equally important to ask them about how they felt around their friends and family (and in society), and how the relation to their body changed as result of the pain episode. In other words, it was necessary to elicit how Muslims think about their body prior to illness, during, and after. This was of both theoretical and empirical

interest because it was important to see if Muslims also fall under the theoretical framework which we have outlined above. This means that we are interested in seeing the utility of Bendelow and William's work, where pain patients seek other cultural/religious explanations to give meaning to their pain (1995: 140), as well as through Leder's absent body during normal times and the reemergence of body-consciousness through illness and pain as pain forces the body to "speak up" (1990: 71). Of course, Goffman and Charmaz's understanding of the body and identity, especially the notion that the body has a significant impact on the ability to manage identities. In this context, it was necessary to ask respondents about their life experience before pain, and the positive/negative effect with which pain left them after their experience or experiences. It was equally imperative to explore the consequences of pain on their identity, as we have shown above the body is very much intertwined with identity. We concluded the interviews by asking respondents how they made sense of the pain and to what extent they employed cultural, medical, religious, or a mix of these components to make sense of their pain experience.

In analyzing the data, we looked at major themes that emerged during the interview process. Following Derek Layder in his *Sociological Practice*, our goal was not to derive our theory exclusively from the data but to use the data to help us refine, rethink and modify the theoretical framework. Layder writes that when working with interview transcripts one has to be open to "a continual reshuffling or rethinking of what the data meant in order to produce new angles, ideas, and explanations" (1998: 63). He further explains that it also involves "a sustained teasing out (elaboration, extension, modification) of the concepts and ideas that were already playing a significant role in the analysis and interpretation of the data" (1998: 63). Thus it is important to unravel the latent meanings found in interviewees' linguistic expressions. We were mainly looking at the meanings that were related to their

understanding of the body, pain, identity and how they are manifested in the discursive expressions of each individual. This means that we did not have the expectation that respondents would use for instance terms such “appearance” or “dys-appearance.”

Nonetheless, we were attentive to terms and themes that pointed to Leder’s concepts. Thus in our analysis, we used the concepts developed in this thesis to organize and understand the data. We also attempted to see the divergences as well.

In order to separate all these major themes and concepts, we resorted to reading each interview more than once to get acquainted with the information. We also compared the data of the eight individuals together to see similarities and differences. Naturally, we concentrated heavily on speech, expressions, and discourse to tease out these latent meanings by underlining each relevant theme and concept. Then we resorted to dividing all the common themes that emerged during the interviews and then compartmentalized the information from the interviews within these categories which we have already underlined.

In the next chapter, we present our exposition of the Shia Islamic world view by drawing on the interview data with Islamic scholars. Following this we present our discussion in Chapter six.

Chapter Five: The Islamic Worldview

Overview

As noted in chapter two, under the section of Sociology of Religion and Religion and Pain, there is substantial evidence that demonstrates that people cope with chronic medical illness by reaffirming or opening themselves up to spiritual or religious practices (Keefe et al. 2001: 101; Conway 1985; Koenig et al. 1992; Heyse-Moore 1996; Puchalski et al. 2005). And as J. Milton clearly shows, one of the most important “manifest functions” of religion is to provide believers with specific life goals that equip them with cultural tools with which to give meaning to events such as death, pain, illness, injustice and “evil” (Cipriani 2000: 155). Also, according to Geertz, religion should be viewed a component in “a cultural system” where culture is understood as a “historically transmitted pattern of meanings embodied in symbols, a system of inherited conceptions expressed in symbolic forms” (Geertz in Hamilton 2001: 177). Given that my respondents were all practicing Shia Muslims, in order to discern the impact of their Islamic worldview on their experience of pain it is necessary to identify the most important elements of this worldview. We are interested here not in its theology but the general way in which Islam relates believers to the objectives of life and how it frames pain. Before describing the worldview, it is important to first say something about how the western medical literature has treated the interaction of Islam and medicine because many Islamic practices and beliefs are put under medical scrutiny as we will see below.

Islam in Western Medical literature

Laird et al. (2007) conducting a Boolean search in MEDLINE using the terms ‘Islam, Muslim or Muslims’ produced a result of 2342 out of the more than 11 million articles and records on this widely used medical database. Even though the number is relatively small, the overall trend shows an increase in interest: for the time period of 1966-1969 there were only 24 papers for the term Islam and its cognates, while for the period 2000-2004 there are 709 (Laird et al. 2007: 2430).

In many of these articles, however, Muslims are portrayed negatively as “others in need of intervention” (Laird et al. 2007: 2430). And additionally, “[t]hose in non-Western contexts are portrayed as less educated rural or urban poor, bound by ‘tradition’ and ‘conformity’ to ‘underdeveloped’ pre-modern beliefs and practices” (Laird et al. 2007: 2430). In this literature, being a religious Muslim often entails important health risks. Devout Muslims are represented as people with pre-modern traditional medicine, unwilling to adopt modern and newly emerging medical treatments and solutions. Moreover, Laird et al. found that most of the latent themes discussed represent daily (and annual) religious rituals as an added health risks to Muslims, like the effects of observing the fast of Ramadan and its relation to peptic ulcer disease, the link between annual pilgrimage known as *hajj* and the “Surveillance for meningococcal carriage by Muslims returning from the Hajj” (Laird et al. 2007: 2430-31).

Furthermore, attitudes towards Muslims become more negative and critical as the discussion centers on women. Veiled women are seen as traditional and premodern and at medical risks insofar as the veil prevents “Vitamin D absorption” (Laird et al. 2007: 2431). Moreover, Muslim women in general are represented as being at higher risk for “for depression and anxiety, due to traditional marriage and family structures” paired with “improper, out-of-control reproduction and inbreeding” (Laird et al. 2007: 2431-32).

Even when it comes to investigating the historical contributions of Muslims' enormous to medicine, the picture is heavily biased and skewed. Medical literature dealing with Islamic contributions to medical science often employ the term "borrowing" from the Christian, Jewish and other cultures when referring to medical advances (Laird et al. 2007: 2434). Simply put, Muslims painted within these texts resemble medieval scribes; their task was simply to translate information from one civilization to the next without making any contributions in their own right. According to the numerous articles cited by Laird et al., whatever Muslims wrote could not have been uniquely theirs and must have been largely influenced by previous civilizations (i.e. Indian, Greek, etc.). The general theme is that of an incompatibility between Islam as a traditional premodern religion and modern, sophisticated biomedicine.

The authors conclude that there must be more critical reading and research into the relationship between Islam and Muslims within the medical field and "...health professionals must read available literature with a critical eye to uncover biases..." (Laird et al. 2007: 2436). Islamic scientific literature could be useful in actually promoting modern approaches and policy in health medicine if treated and analyzed properly. In this case, Laird et al. suggest that "[t]he restrictions and prohibitions" central to Islam's laws of prescriptions and proscriptions in terms of body and health, "interest some epidemiologists as protective factors and some policy makers who are designing public health education programs" (2007: 2437). One avenue for opening up the field is to explore, as we are doing here, the impact of Islam as a worldview on the experience of pain. In the next section we begin to sketch out some of the broad features of the Islamic worldview. We then go on to summarize and analyze the responses from the scholars that we interviewed.

Islam's worldview

The goal of this research is to try to develop an approach towards understanding how Muslims, specifically Shia Muslims, interpret pain and what role an Islamic cultural framework plays in their understanding of medical pain and suffering. As we have outlined in the introduction, we specifically want to focus on the relationship between the experience of pain and religious worldviews as the significance of this relationship is suggested by a number of contemporary scholars that point to how religious and cultural worldviews and interpretations allow individuals to more effectively integrate pain into their everyday lives and to frame it within a meaningful context (Bendelow and Williams 1995; Keefe et al. 2001: 101; Conway 1985; Koenig et al. 1992; Heyse-Moore 1996; Puchalski et al. 2005).

We particularly want to explore to what extent contemporary Islamic practices contribute to individuals' framing, experience, and understanding of pain. However, before presenting our analysis of the interviews, it is pertinent to briefly sketch how Muslims understand the world, and more specifically how Islam shapes and gives meaning to the world for Shia Muslims. Note that this only seeks to provide a window into Islamic/Muslim understanding of the world, and should not be read as some alternative Islamic sociology. Our goal is to identify some of the most important cultural themes that structure the Islamic worldview.

Islam is a monotheistic religion, and according to the Quran, Islam is the last revelation of the Abrahamic religions. With it, centuries of scattered revelations come to an end. As in Christianity and Judaism, Muslims believe in one God, in His Prophets and Angels, as well as reward and punishment (Hell/heaven). Like in other religions, as Weber argued the ethical codes and the elaborations of the good life and of sin are all intimately linked with a yearning for "salvation" (Weber 1969). Much of the explicit purpose for Muslims on this earth is to seek 'salvation'. This means that Muslims adhere to a set of

moral precepts and behavioural practices that are culturally patterned and integrated in order to attain salvation. Not surprisingly, Islam is also made up of competing interpretations of the Quran (even though they all agree on the contents of the Quran). The Islamic scholar, Khaled Abou El-Fadl, writes that “all Muslims accept the Quran – the divine word revealed to the prophet Muhammad. Therefore, the Quran is considered to be the literal, authentic and unadulterated word of God” (2005: 114). Differing interpretations have however led to the formation of five main Islamic schools of thoughts of which one of them is the Shia school of thought (also known as the Jaaferi).

Today, Islam is practiced in various parts of the world in many different forms. A researcher would experience great difficulties in identifying “orthodox” Islam. Moreover, contrary to common held beliefs, Arabs do not make up most of the Muslim community: they actually represent a small proportion of the over billion Muslims worldwide (Grieve 2006: 163). Practicing Muslims, are required to observe some mandatory tasks (they are known as the branches in Islam) such as fasting (one month of the year), praying (five daily prayers), pilgrimage to Mecca (if feasible), paying taxes (*khums* which is literally 20 percent), and *zakat* (a sort of tax, usually applies to rural dwellers and not urban dwellers). The purpose of these mandatory actions is to keep the cornerstone of piety and salvation. Thus not performing them is considered a sin in Islam. C.T.R Hower in *Understanding Islam*, claims that “these practices are a training program to build *taqwa*, God-consciousness, within the Muslim so that she or he may be led into the perfect state of *Islam* [submission to God] and thus be both happy in this life and rewarded with Paradise in the Hereafter” (2006: 88).

However, preceding these are the bases or pillars of Islam. The Islamic base rests on five fundamental pillars that every Muslim has a duty to know. These fundamentals form the

mindset and actions of any practicing Muslim. El-Fadl writing about the importance of these pillars says that they “are considered the heart and pulse of Islam, and it is often asserted that believing in and accepting them as the foundational articles of the faith differentiates individuals between a Muslim and a non-Muslim” (2005: 113). These pillars are the following: Oneness, (Supreme) Justice, Prophethood, Imamate, and resurrection. With respect to oneness, Muslims must believe that there is only one God, while supreme justice means that God is not unjust but is indeed very just, thus every injustice on this earth has to be attributed to individuals and not to God. Prophethood simply means that Muslims must believe in all the Prophets before Muhammad, the latter being the last prophet or the seal. Imamate (specific to the Shias) refers to the belief that the Prophet left successors after his death (in other words the Shia community was not bereft of ‘heavenly’ guidance). Lastly, resurrection, one of the most important of these five bases, is meant to remind an individual that this life is naught but a test and indeed transitory; thus, for every action an individual does whether (good or bad) there is eventually a supreme justice that will judge all humankind on the day of resurrection. In writing about the idea of death and resurrection (among Muslims), C.T.R Hewer claims that “death is inevitable according to Islam” and that for Muslims “this life is a test that prepares them for death, which is the point of transition to the afterlife” (2006: 84). Dealing with life in general, Hewer adds that “during the various ups and downs of life, human beings [or Muslims] are taught to cultivate the twin pillars of *taqwa* (God-consciousness) and *sabr* (patience)” (2006: 84).

Other than the Quran, Muslims have two other sources for guidance. The first of these relates to the Prophet’s sayings and actions, compiled and expounded upon by his successors (Imams) known as *hadith* or *ahadith* (literally meaning ‘narrations’). These serve to guide Muslims in all areas of interaction and faith because the Quran did not elaborate

specifically on everything (the narrations are seen as a completion of the Quran). The third are the *alim* or *ulema* (literally scholars or jurists) who study the Islamic sciences and bring forth their legal opinion on all the pre-modern (e.g. what is the most appropriate way to perform ablution) and modern issues (i.e. is cloning permissible?). Those who attain the level of *ijtihad* (highest level of jurisprudence), which is the equivalent to the Judges of the Supreme Court of Canada, usually draw followers who regularly seek their opinion on religious and worldly matters. In this regard El-Fadl comments that “Islamic jurisprudence is a legal system every bit as complex as the civil law, common law, and Jewish law legal systems” (2005: 30).

Islam, Pain, and the Body

In our research we have not been able to identify a specific Islamic study on pain (at least in the English language), therefore we have had to rely on my interview data with Islamic scholars in order to identify the relationship between pain and the body. The scholars were sent letters and then phoned personally by the researchers as they proved to be harder to reach than the other respondents, whose recruitment is explained in the next chapter. Because of their busy schedules, many scholars referred me to their students to answer their questions, but in a way this helped the researchers because these student/scholars spoke English more fluently. The scholars were interviewed in their own respective offices and their answers were recorded and transcribed.

All the scholars we interviewed are Shia Muslims (3 males and 1 female), ranging from the age of 28 to 64. Three of them, El-Zein, Mohammad, and Fatima, are of Lebanese origin, while Sayed Zihashem, the eldest, is of Pakistani background. All of them have lived in Canada over five years. El-Zein and Fatima are both continuing their studies at the

Windsor *Hawza* (Islamic University), and have not completed their fourth year yet. While Mohammad is a scholar himself, he nonetheless gave me the opinion of his teacher. Fatima has a degree from Lebanon in computer engineering yet she wished to continue in Islamic study as she wanted to learn more about Islam. Sayed Zihashem is an entrepreneur having worked in his insurance company for over twenty years. However, he never left his Islamic studies and completed them part time over many years. He has recently left to Syria to continue his studies.

The scholars we interviewed converged and diverged on the Islamic meaning of pain (and the body). However, all the scholars we interviewed commented on the three essential features of pain namely, A) the meaning of pain B) the purpose of pain and C) the function of pain. Since pain is very much linked to the body, the body is also an important theme in their comments. This discussion about the three Islamic attributes of pain allows us to further understand how Shia Muslims give meaning to their pain and how they culturally define it outside of but without necessarily rejecting the biomedical paradigm.

As noted above when discussing Iain Wilkinson's work, defining pain can be extremely challenging in sociology. However, a definition is an important cultural aspect of pain since defining pain is a step towards including pain within a framework of meaning and providing coping strategies, allowing individuals to make sense of it. Consequently it is an important part of any religious cultural system. We now report the definitions provided by the scholars that we interviewed. The first scholar, Sayed Zihashem, claims that pain "brings to [the] mind the [concept of] suffering" and is also intricately linked to the body. He continues by asserting that pain is worldly and, thereby, affects every individual. He adds that "pain is very much in this world [as opposed to the afterlife]" and "we attribute [to pain] the physical essence [namely the body]". He continues by saying that "pain is a thing that

you cannot describe because it doesn't have a shape, it doesn't have a colour, and you cannot feel it [materially by sense of touch]." He added that "the only person who can feel it is the person who is suffering with pain". This difficulty in attempting to define pain is an agreement with the difficulties that Iain Wilkinson identified, namely pain's subjective nature.

The second scholar, El-Zein agreed that pain was a "feeling that's kind of annoying ... sometimes spiritually" which comes without warning. The third Islamic scholar, Fatima, describes pain in this manner: "pain is agony, and suffering, it could be both pain in the mind and the body" as well as a "feeling". El-Zein further expands on this 'feeling' by asserting that "it's something within you, it's just like love or hate, it is like those other feelings that is connected to your emotions and more so to your physiology [i.e. the body]".

According to these Islamic scholars, pain does not only carry a cultural meaning, but it also carries cultural significance: being in pain is connected to the actions and behaviour of an individual. As for the function of pain, the four Islamic scholars were adamant about pointing out that culturally, pain serves as a reminder to the individual about their weakness, while pain's (higher) purpose is supposed to bring the individual back to their 'nature, that is to say it is meant to remind them of the existence of one God or higher deity.' This means that pain helps remind people of God, their creator, and they should take this time to get more spiritual or religious. In this sense, these Islamic scholars pointed out that generally Muslims undergoing pain tend not to see it as meaningless because for Muslims pain has a meaning and a purpose other than the sheer hurt. Mohammad, the fourth scholar, explaining this purpose and the higher meaning of pain, says that pain can be understood as a "punishment from God" or "atonement for sins" striking a similar tone to the Christian religion (Puchalski et al. 2005: 116). This is a clear illustration of Hamilton's claim, that

religion helps believers cope with pain and suffering by inserting pain in a “meaningful context”, and by providing cognitive and behavioural practices that allow believers both to understand and talk about the pain: “[t]o be able to understand it is to be able to accept it and endure it” (Hamilton 2001: 179).

Mohammed does note that in most cases when humans act improperly they “cause pain” and in this sense, “pain serves to put the individual back in his or her place because God wants to save humans [from further sin]”. In this sense, pain is a sort of salvation. Sayed Zihashem reemphasizes this point by asserting that “any suffering [i.e. pain] that a human being undergoes through is because of their own mistakes.” Thus all of humanity’s pain is not due to God but as a result of “some mistakes that we have made”. However, El-Zein has a slightly different understanding of the Islamic explanation of pain. He notes that while pain might have severe consequences like becoming a “calamity and an obstacle in life”, humans should not forget that pain should be also seen as deriving from “God’s mercy and from God’s grace” because people should be more preoccupied with the spiritual outcome (i.e. the function). Further, El-Zein is quick to note that “one of the greatest bounties from God is that as soon as you feel that pain you tend to seek a path towards God”, in this way an avenue to salvation becomes available. Fatima notes the same function for pain, namely that human folly and misconduct is the general cause of human pain. However, she does emphasize that pain functions mostly as a test and as a reminder if the individual is willing to “cling to God, pray to Him and obey Him and not to blame Him” and accept responsibility for being the root cause of their pain. This Islamic view of pain provides Muslims with ‘meaningfulness’ as well as a special coping strategy when confronted with pain. However, Islam is no different from other religious worldviews. As previous studies have shown, in time of pain, people tend to seek out a religious or quasi-religious framework as religion tends to give

meaning to something that appears to be beyond human comprehension (Bendelow and Williams 1995; Keefe et al. 2001: 101; Conway 1985; Koenig et al. 1992; Heyse-Moore 1996; Puchalski et al. 2005).

While culturally for Muslims, pain carries both a meaning and function, it nonetheless has a (higher) purpose. As we have outlined in the section *Islam: a Worldview* Muslims are preoccupied with the issue of salvation, i.e. Muslims believe that this life is naught but a test or a place of performing good deeds so they may enter paradise or the hereafter. In other words, Muslims see this world as transitory, full of trials and hardship and those who endure these trials and hardship are the ones that will be rewarded most and will enter paradise. Thus pain has more than just meaning and function, according to the Islamic scholars, it is one of God's "tools" for the purpose of attaining salvation, accessing heaven. While the function of pain might serve to bring people back to "commonsense" and "doing good deeds" or "realizing the existence of God", within the Islamic worldview its higher purpose is also to facilitate the entry of individuals into heaven. Mohammad says that "this earth is transitory, meaning that it is a stop or a place of rest before we go to another place [i.e. heaven or hell]" and that "when they [i.e. individuals] feel this sudden pain, they most likely return back to their creator because this pain reminds the individual that they are not in complete control of who they are, their body and their life, they realize that there is something beyond them, something higher than them". El-Zein adds that the ultimate purpose of humans in this life is "to obtain the highest level of worship towards God" and pain is one of the many vessels that can bring an individual back to his or her creator. The purpose given to pain, then, also helps Muslim not just to explain pain but in a sense to revere it (as in the Christian religion), as something that can bring them closer to the purpose for which they were created., i.e. guide them towards their entry into heaven. So while

Muslims do use modern medicine to seek treatment for their illnesses, they nonetheless still regard pain as having a higher meaning, function, and purpose.

Furthermore, religions, such as Islam and Christianity, strongly emphasize the relation with the body due to multiple factors. On the one hand, our bodies as noted above provide the material and the symbolic material around which our identities are organized. As individuals, we identify ourselves with our bodies. As we noted in our theoretical chapter, bodies exist at the intersection of the material and social world and are important carriers of social capital. Inevitably, for many individuals anything done to their bodies is simply done to them (or their selves). So then it becomes very clear that “[p]art of the reason our bodies matter to us is that we strongly identify our very selves with them. We experience things done to our bodies as done to our selves” (McGuire 1990: 284). On the other hand, because we live in society, bodies take on a much more complicated role. Bodies become an invisible marker for health and more precisely a crucial marker for the continuation of “normal” social relations within communities as outlined within the work of Goffman and Charmaz. In Islam, bodily pain is a moral indicator of the actions and decisions of individuals for it is they who are ultimately responsible for the pain that they feel.

Consequently, Islam as a cultural framework also encompasses the body and mind, as well as the spirit (self or soul). There are many sanctioned rituals that Muslims must perform and many prohibitions from which Muslims must remain aloof. Islamic religion with its laws, texts, and narrations “go into great detail regarding the management of the body, in order to obtain (or maintain) spiritual and physical cleanliness and purity” (Tober and Budiani 2007: 7). In other words, Islam has its own collections of “techniques of the body” or “vocabularies of body idiom”. Muslims cannot harm themselves or inflict pain upon one another; they also are prohibited from committing suicide. They are required to seek medical

solutions if need be, and anything in general that is culturally considered harmful to the body cannot be practiced by them (like eating pork, drinking wine or alcohol, etc.), even though their prohibition does not ultimately rest on just a purely medical condition. Sayed Zihashem, explains that “when people eat foods that are not compatible with their body, we become responsible for polluting our organs and the body more generally” and thus Muslims and generally individuals should refrain from bringing any harm to their body which might cause them unbearable illnesses and pain. Also, all the Islamic scholars agreed that Muslims are instructed and advised to not eat for their fill, but to eat one third food, one third water, and one third left for air. They must also be selective in their eating by choosing healthy and appropriate foods for their individual conditions. Muslims are also advised to avoid harmful combinations of foods that might cause unpleasant bodily responses. Specifically, then, these rituals and daily injunctions laid out by Islam without doubt affect a Muslims’ relationship to his/her body. Tober and Budiani in their pioneering discussion of the relationship between Islam and health argue that “[t]he specific role of religion is to control and regulate the body for the purpose of physical and spiritual purification. In Islamic theology, religion, law and medicine are integrated” (2007: 5). In this context, Sayed Zihashem says that culturally the body is seen as a “vessel” for the soul and “the individual has a 100 percent responsibility to take care of the body... like a very expensive gift” because “if we abuse it then we will suffer”. Essentially then, the body is a delicate and intricate medium which the self inhabits so it can fulfill its daily functions. In order to fulfill these functions properly, the Islamic scholars assert that the Quran and prophetic narrations have stipulated many rituals that bring about awareness of the body and also help humans take care of their bodies. Concern for and care of the body are integral components of the Islamic world view. As we will see in the next section, it is a recurrent theme in the

interviews with S.U.P. respondents. In addition, within the Islamic cultural system, the body is the carrier of meaning and signs that have to be carefully read and deciphered. For Leder, pain forces the body to “speak out”, and thus for Muslims the body and its pain communicate to the believer his or her proximity to God, the extent to which his or her life is in accordance with a good life and the prospect of fulfilling their human purpose of entering heaven. The materiality of the body is thus not divorced from a Muslim’s spiritual life. An unexplained pain, not only indicates that there is something wrong with the body, but also something wrong about how individuals are living their lives. The religious requirement to take care of their body not only obligates them to moderate their behaviour, but also to seek biomedical help when it is required. Thus there is not necessarily an inseparable opposition between Islam and biomedicine. One must deal with physical causes. In addition to this, though, pain is also taken as a sign that perhaps one is not living a godly life. Therefore, medical attention is not sufficient; spiritual self-examination and modification of behaviour may also be required. As we will see in the next chapter, this is also a theme that emerged in the interviews with sufferers of S.U.P.

Chapter Six: Analyzing the Data

Overview

In this chapter, we will discuss our analysis of the eight interviews with my Muslim respondents who have undergone S.U.P or chronic pain. In doing so, we will address the following themes of pain, body, identity, and religion, which have emerged as being significant in this research. All the respondents we interviewed ranged between the age of 26 and 35 (5 males and 3 females). The participants were recruited through poster advertisement in centers of worship (mosques) between mid-May to mid-June 2008. All respondents who called were screened through an eligibility form, which was administered on the phone. In order to be eligible to participate in these interviews, respondents had to have been in a situation where they had experienced pain that was sudden, unexplainable, and prolonged. This physical pain must have been of sudden appearance without any evident medical cause. Therefore, brief episodes and pains with known causes were excluded (i.e. childbirth, physical trauma, violence). These criteria helped narrow down the search for a specific type of pain, i.e. S.U.P. Assigning them pseudo-names, most of the participants were of Lebanese background with the exception of three (1 female and 2 males) who were of Iraqi nationality (Xena, Ali, and Naqeeb). Five of them (Nisreen, Yasmin, Wissam, Ghassan, Hussein) work in professional jobs in for the Canadian Government, while Ali works in the private sector for a computer software company, Xena, while having a bachelor degree, was currently at home taking care of her two children, and only Naqeeb was not working, but was in the process of looking for a job. Of course, during the interview, each respondent's personality differed, while some were eager to "let it all out" like Nisreen and Yasmin, some seemed to be in a bit of a hurry like (Xena and especially Hussein).

The interviews took place in the University of Ottawa, in one of the rooms of the University Centre. In most cases the interviews lasted around 20 minutes. However the shortest interview was 15 minutes and longest close to half an hour. All the interviews were recorded and then transcribed for further analysis. Respecting the respondent's privacy, all papers were given pseudo-names to conceal their identities, and locked away.

Results

We have organized the presentation of our results around the following themes that emerged from our theoretically mediated analysis of the interview data: definition of pain, the absent body, lack of control, embarrassment and stigma, the scared canopy, and religion as an alternative framework.

Defining Pain

In attempting to define pain, all respondents tended to see pain from the individual perspective of their own suffering. Naqeeb, who had a severe throat virus, describes his pain as mostly an "ill-feeling, something that you don't want to be part of or to have to go through and yet it's always there" while Xena, diagnosed with chronic dizziness, explained pain through terms such as "weakness, vulnerability, and hurt" and by further claiming that "I don't like it . I don't think anybody likes to go through pain. It something that you can't control." Wissam who suffers from chronic shoulder pain referred to it as "discomfort," he says that "it's a scary thought because it's really uncomfortable when it happens. And I've had it for a long time... I feel weak in front of it." Another respondent, Hussein, suffering from chronic back pain linked the word 'pain' to just his lower back while another respondent (Ghassan) with chronic juvenile arthritis referred to pain as "my finger and my

bones in my hands.” A female respondent, Nisreen, suffering from Ulcerative Colitis (an inflammatory bowel disease) for seven years, said that “well when I hear of pain to me it means, suffering, it means sleepless nights, it means you know taking medication or it’s something usually not a positive thing. It’s something that gives me a lot of grief sometimes. And sometimes I cannot deal with it or it’s stronger than me.” Yasmin suffering from migraines also reiterated the fact of “not enough sleep” but also added “head pounding” and the inability to focus. She said that “the first thing that comes to mind is, I guess head pounding, not enough sleep, not being able to focus. I guess not being able to put everything into perspective.” She also saw pain as “a kind of disability” as it interrupts the normal flow of routine or daily functions. The last interviewee, Ali, who suffered from unexplained but prolonged chest pain, explained that pain was the cause of his misery in missing “everyday activity” and always thought about how to “get rid of the pain.”

The absent body

Most of my respondents noted how their body (before pain and disease) was absent. Often terms like “neglecting”, “didn’t notice”, “carefree”, “careless or lack of care”, or “other” was used to describe their relation to their bodies before pain. Xena diagnosed with chronic dizziness says that “I was put here to do whatever I wanted. Like I felt like there were no boundaries, like I was going to live forever kind of thing. You know I always thought that, you always see people around you dying but for me it was like I can’t imagine myself dying.” Wissam described his relation to his body before pain: “I was more carefree, careless... laid back, relaxed, didn’t care for much.” Ghassan, who has episodes of juvenile arthritis said: “to be honest I never really thought about it [i.e. the body].” Nisreen, asserted that “I never really thought about it. I always felt like one piece... but ever since my pain and

my disease, you know I felt like there was two of me. There was me and my body that was just you know failing me, hurting me.” Other respondents referred to their body as “not being there” or the body as almost having a ghostly existence or being non-existent. Wissam, who has severe shoulder pain, never thought about the his body, and only after his illness did he realize that “the body is weak, and that’s all we have and we have to take care of it otherwise, there’s not much else we can do”. Pain tends to bring back the body to existence or make it real and alive again, the respondents described their new relationship to their bodies in many ways. This new relationship took the form of mainly recognizing the existence of their bodies and the need to become more “appreciative”, “aware of”, and “careful” with their bodies. Wissam, who had aspired to be a professional athlete, characterized his new relationship with his body as being based on “extra care” or being “more aware.” Xena suffering from chronic dizziness asserted her new relationship to her body by claiming that pain was a positive experience: “I started to appreciate my body more, and take care of myself more and appreciate everything around me”. Hussein, who works with the Ottawa Police force, responded that his chronic back pain made him aware of the limits of his body. Thus he is now more conscious about what he can do or cannot. He said that “what has changed though is my physical capabilities and that now I am not able to do everything I can” and that “now I know that I have to take care of my body. I have to know what I eat, what to do and what not to do, even what sports I can play or what sports I can’t play because of it.” Wissam suggests the same debilitating effect of his pain on his ability to continue his dream of competitive sports as he has become more aware of his bodily limits. He laments that his life “is on kind of hold” and he is unable to participate in these activities. Yasmin also seeing her body through a different perspective, claims that pain “humbles” you in view of your relation to your body because now you are more conscious about the

“sensitivity” of the body. For Yasmin, pain has also had an “awakening” effect on her relationship with her body, while Ali who suffered from chest pains, claims that not only is he more careful but more “fearful” about what he does with his body. Ali further says that “I should have watched what I ate, I should have exercised more, I should have watched my body and taken care of my body because you know when your [chest] muscles start hurting you think of heart problems, and you think of cancer, a lot of things start going through your mind and when I’m feeling perfect I think my body is going to stay like this until the end of my life.” The repeated term of vulnerability and the need to be more careful and aware not only draws attention to the idea of vulnerability but also of responsibility. Perhaps if they had been more careful, more aware earlier they might have been able to avoid the pain. This sense of responsibility also strongly reverberates with the Islamic worldview described above. Pain is seen to arise from the ill deeds and actions of individuals.

Lack of control

Many respondents expressed on many different occasions how the body has not only failed them but had been out of their control and it had not lived up to their expectations. When individuals referred to how their bodies “spoke out,” all the respondents made reference to a “lack of control.” Nisreen who is still suffering from inflammatory bowel disease emphasized the fact “that my body failed me” and how she does not have control over her body or now has only “limited control.” She also adds that “the way I dealt with this [pain and illness] was not giving up, but by submitting to a higher power knowing that I don’t have control over my body.” Yasmin, describing her experience with migraines, exclaims her disappointment at not being able to “control” or as things not “being in your control” and how she just “can’t control” the pain and her situation. She describes her life before these

episodes as being “in control” and as “having the ability and freedom to move about” without worry. She has come to realize that in the end she is not the master of her own body because the body, as Ricoeur says, has its own functions and “wisdom” (Ricoeur in Leder 1990). Yasmin further adds that the body is

not in your control so therefore, I mean you can somehow make, diminish the suffering but generally it's not in your control. [but] it gives you that feeling that you always try to control yourself ... you try to control yourself so that the suffering is less. But yes, at the time [pain] you really feel you're not in control because this [migraine] happens once a month so therefore I can't control it... you do feel a way that your body is different. Like you can't basically you can't control and what you can't control, you feel is a bit alien to you.

Also both Ghassan and Xena expressed their frustrations with their bodies because of their inability to “control” it, which has made them both uneasy and “scared.” Xena said that “I had no control of the pain and no, no matter what I did or who I saw, doctors or what not, they didn't even know what it was so it was something that I couldn't control.” Others, like Hussein explained how the lack of control over their pain has made it “strange” how he “can't control a bit of pain” which has forced him to “change his daily routine.” Thus, he continues, “the back pain that I get ruins everything. It makes me unable to do anything that I used to do before.” Wissam also notes how pain, with its devastating effect of chaos on ordinary life has “ruined all” his ambitions and dreams of becoming a professional athlete. He says that

I can't do that [i.e. play sports], so it feels like a whole part of my life, and I'm a big avid sports fan, a whole part of my life is kind of ruined. It's on hold until I do something about the shoulder. I feel like I can't participate in the activities the family get-togethers, I'm just in a lot of pain when, whenever I do exercise or do anything. So I feel kind of you know unable or incapable, uneasy.

Naqeeb, who suffered from a severe throat virus, says that "when I was around them [family] I would feel secure, except that if the pain was there and it was, it would hurt a lot. I felt like I was alienated from them because no one could do anything about it. And it was something inside of me and yet I couldn't do anything about it either." It is worth noting that continued reference to the need to be more careful and vigilant, which we described above, can also be understood as a way of trying to reestablish some sort of control over a body that has become foreign.

Embarrassment and stigma

The respondents all complained about how their specific illnesses and pain transformed their view of their selves and in detail expressed how they felt. In the end they either changed their identity or readjusted their goals to cope with their emerging situation. According to Goffman this is what happens when one loses their virtual social identity and s/he becomes a clear marker for difference of a "failed" person in society. Nisreen says that "she felt trapped" like "it was not her." She also felt separate from herself because she felt that such pain had the power of disassociation. She said that "when you go through such pain and suffering you tend to disassociate yourself, meaning your personality [i.e. identity]". Comparing herself to others, she indirectly refers to Goffman's virtual social identity. She

says that when people walk outside “they all wear masks” but sometimes you wonder “what’s under the mask” or what is their real social identity. Nisreen sometimes felt “alienated” and “left out in certain situations” because others “cannot understand how severe her pain” is. She also felt a linguistic divide as she was unable to explain to others how her pain really feels. Furthermore, Nisreen is aware of how much pain can strip one’s sense of self. She thinks pain has negative consequences for the personality as “it takes so much away from an individual’s vitality, from independence, and the joy of life.” Other respondents like Yasmin and Xena felt “weak”, and “vulnerable”, while Ali felt “depressed” because now he was more “fearful” and “scared.” Naqeeb felt very “alienated around friends and family because no one could do anything about it.” He later mentions that he felt like he did not feel like himself, and that most of the times he just wanted “to be alone.” Wissam, who had aspired to be an athlete, said that he felt “unable or incapable” of doing things and this has rendered him as a person who “cannot do anything.” However, in Hussein’s case, who needs his physical strength as a police officer, he claims that “I feel vulnerable” because being weak is not part of who he is. Most of them have additionally claimed that their lives are not the same as they are incapable of meeting certain social obligations. This has meant, as Charmaz demonstrated in her research, that they adapt, change or accept their situation. However in most cases, even though some still pose why questions, they have accepted their situation and have adapted their needs to their abilities.

The sacred canopy

Most of the respondents used a cultural framework to accept or to “accommodate” themselves to their illness and pain. Hence with emerging identity problems, individuals begin to relate to other cultural or religious avenues to help cope with their identity issues.

As Bendelow and Williams argue, “these explanations for suffering may be linked to deeply entrenched religious or spiritual beliefs, even if an individual does not follow any particular faith, and punishment and self-blame are common themes” (1995: 154). Two of the respondents, Naqeeb and Nisreen, invoked the notion of “karma”, and were worried that their illness and pain had to do with “how good” they had been. Naqeeb asked himself: “like why do I have to go through this thing, especially when I thought you know I was generally a good person. Like am I selected for this? Why? What did I do? Is it karma that’s coming back?” Nisreen said that “sometimes I rationalize that there’s a reason for this. You know there’s God, you know there’s a reason for this. God has given me this disease. And I know it sounds a little weird but it’s, there’s a reason why I have this disease.” Feelings of self-reproach and self-blame are common themes, as they feel somehow responsible for their situation. All of them expressed this frustration through the questions of “why, why me, why not someone else” as identified by Pulchalski et al. (2005: 115). Nonetheless they accepted that their pain could be understood within a religious context. Hussein, says that a religious framework has helped him “relieve himself of the pain” but nonetheless he still sees this as a period of trial “to see how deep his faith is.” He often praises God and thanks God for his situations as he compares himself to others who could be in a more complicated situation. Hussein says that “my thought and my religion and my culture is that no matter what you feel, no matter what happens to you, you always ... thank God for what’s happening to me. And the reason for it, is that there’s always someone worse off than you are in this world so thank God that you are not that person”. Wissam also reiterates the same thought. He believes that his situation is a trial, and so he trains himself to think that he must endure it with patience and to “take it as is”. Others talk about how pain has “awakened” them and brought them “more in touch” or “closer to God” or made them more “compassionate”

because they had been living “selfishly”. Some claimed that they “started running back to God”, “felt stronger and more connected to God, and “prayed more” and felt like religion had helped them through their times of difficulty. Some realized there was “a greater power” than them. They positively interpreted things as being out “of their hands”. In other words the pain did not just indicate a loss of control but also the existence of a higher purpose. In a less formalized sense, the respondents echoed the themes raised by the Islamic scholars in terms of the meaning, function and purpose of pain. This religious paradigm has sometimes helped them make sense of their situation when medicine has failed.

Religion as an alternative framework

Using a religious or alternative cultural paradigm is often a substitute for the lack of a medical explanation to pain. In five separate cases, my respondents talked about the inability of professional doctors and medicine to provide answers, let alone satisfactory explanations of their situations. Xena who complains from chronic dizziness says that “I had no control of the pain and no, no matter what I did or who I saw, doctors or what not, they didn’t even know what it was”. Ali, who had severe chest pains, was told by the doctors that as you grow old you get “funny pains here and there” and it’s “nothing serious” even though he had it for one year. Wissam, who suffers from a chronic shoulder pain highlights the inability of medicine to cure his pains says that “medicine has not been able to do anything for me... I have gone to a chiropractor, and psychiatrist” and “all that that has done nothing for” him. The fourth respondent, Naqeeb, suffering from a severe throat infection, says that “no one had an answer even doctors, they would always says something like ‘Yeah, it’s just a viral infection, it’s in the season’”, but “six months is not a season” he adds. Later in the interview, he explains that “medical science today could not [provide] answers, [one time

they say] it was a virus, or take an Advil or just relax, drink a lot of fluids and everything will go away” and “nothing ever solved it”. And the fifth respondent, Yasmin, talking about drugs’ ineffectiveness with respect to her to her migraines, laments that “even if you take any type of medication and you go to sleep, it doesn’t help”. Later she says that doctors did not understand her situation “until one of the doctors said ‘Oh it might be, you know a classical migraine, and that could be what you’re undergoing”. This brings us back to Ware’s argument about the delegitimizing of experience that medicine and medical professionals tend to impose. In more than half of these cases, individuals felt like the medical community did not understand their illnesses and had no medical classification through which their pain could be explained. Thus employing a religious cultural framework opened up an alternative explanatory universe, allowing respondents to cope and make sense of their medically delegitimized experience.

However, I should note that most (7 out of 8) the interviewees are already practicing Muslims except for Nisreen; it would have been interesting to see the effect on non-practicing Muslims. However, this remains beyond the scope of the present thesis. Six out of eight interviewees spoke about how much support they got from friends and family but it is customary and cultural that they should refrain from overtly speaking and complaining about their illness and pain. Also they exhibited a strong sense of self blame about their situation and a sense of responsibility for their situation. The male respondents especially complained that being seen ill in their community is not viewed very well as it is the man who is supposed to be the breadwinner and the “able one” in the household. The men said that their pains prevented them from completing their chores as they felt a very strong sense of an ‘obligatory’ duty. The female respondents expressed themselves much more openly and

precisely than the men. It is possible that the men did not want to show too much “vulnerability” or “weakness” in front of male interviewer who is Muslim as well.

Discussion

As noted above, for Leder, the body is characterized by its absence as a source of direct experience in our every day lives. Leder writes that people are usually not aware of their body or even of their “I-ness” as they engage in daily taken for granted activities (1990: 46). This lack of awareness however is short-circuited in the context of S.U.P. After severe illness and pain, the body “speaks out”; there is a general feeling of a “lack of control” as pain sufferers realize that they are incapable of controlling their bodies in effortless ways. This lack of control does not just refer to individual control but also of biomedicine more generally. The feelings of uncertainty and bafflement are not theoretically or empirically unexpected because as we have seen pain has the tendency to shatter our social construction and reality. Our inability to control our bodies and as result our daily social activities also puts stress on our ability to maintain previously held identities and maintain a sense of self (McGuire 1990; Charmaz 1995; Goffman 1965). All of our respondents provided evidence for the utility of this general framework. Their responses could readily be made sense of using this approach. In addition, Goffman and Charmaz’s work also proved useful in analyzing the data. Goffman reminds us that if a person possesses attributes that differentiate him or her from those attributes expected of someone in his or her situation, then that person is ultimately reduced from being whole, and becomes a carrier of physical and social failure (1965: 3). Charmaz also argues that this type of bodily and social “failure” can also undermine an individual’s life and social identity precisely because this chronic pain weakens, challenges, and negates valued images of the body. This is exacerbated by the fact

that most chronic pain sufferers have “lasting bodily losses” (Charmaz 1995: 659). Moreover, according to Bendelow and Williams, as a result of emerging identity problems, pain begins to be understood by drawing on or intensifying commitments to religious or quasi-religious worldviews. Thus individuals might seek new or reinforce existing commitments to religious worldviews as a way of dealing with this new physical and social situation, through its use as a “sacred canopy”. This is because, as sociologists of religion have convincingly argued, the purpose of religion is to provide answers and to give meaning to inexplicable events of pain, death, and illness (Cipriani 2000). In this sense, religion does not only give meaning, but also makes sense of disruptive and disordering experiences that otherwise might rupture our social reality. As Puchalski et al. note that religion, in this case, helps people to cope with their illness, loss, and pain by providing the sufferers with meaning, and most importantly an acceptance of their situation. Using this cultural/religious paradigm is often a substitute for the lack of medical explanation to pain.

If illness, pain and disease are always potentially disruptive of social activity and identities, it is particularly disruptive when biomedicine, the most significant cultural idiom we have for understanding pain is “confronted by its own limits”: namely when it cannot satisfactorily explain pain as in the case of chronic pain and S.U.P. Because of this, medicine seems at times to be irresponsible to patient needs and complaints. This is also in accordance with Ware’s research on sufferers of the CFS (chronic fatigue syndrome): she attests that for sufferers of CFS, the lack of recognition by the medical community of their dire condition only meant that there was no efficient diagnosis of their chronic pains. In most cases, these patients felt “betrayed” as medical intervention seems to have come to a halt (1992: 351). When they failed to get adequate answers to their chronic suffering, they devised their own illness management strategies. In the case of my respondents, this strategy was already

culturally “built-in” through the use of religion in the face of inexplicable and insurmountable chronic pain. In this case, Islam as a religion and a cultural paradigm provided these Muslim individuals with a framework to accept, explain, and understand pain. As soon as pain alerted them to the appearance of their body, these respondents drew on a cultural/religious interpretation of pain. They saw the body as a sign that literally “speak out” about their (mis)deeds and about their level of religiosity. The body in pain served for them as a sign from “above” to seek remedies to their social behaviour. Obviously, even though all of them consulted doctors, they saw medicine as unable to explain the “higher order” and purpose of pain. This however does not necessarily suppose a complete rejection of medicine.

As we have seen through our discussion, Shia Muslims used the cultural Islamic understanding of their pain to make sense of their situation. Through their words, they conveyed a sense of their everyday normality being disrupted through the eruption of their bodies in pain. This became quite problematic as they realized that their body was literally out of their control. This forced them to question their identity as they were unable to carry on the bodily activities underpinning their identities. However, because of their religious background, they used their Islamic cultural point of view to integrate pain in their daily lives. Thus they explained their pain as a means to an end, like a trial or a test for eventual salvation. This religious and cultural framework helped them to overcome obstacles in their lives. They saw this as a defining moment in their relationship to others in this world and to God in general. Thus, for Shia Muslims pain is a social and spiritual indicator of not only whether they are good Muslims, but it also serves as a reminder of their general purpose on this earth. Thus the physical body through sudden, medically unexplained, and prolonged pain served as a social and cultural system of spiritual and social realignment. Furthermore,

contrary to much of the literature dealing with the relationship of Islam and western medicine, discussed in chapter five, Shia Muslims respondents all reported that they had visited their doctors or relied on biomedicine to learn about the nature of their pain. Even the scholars talked about medicine and the importance of medicine and the body to Islam. This blunts efforts of some researchers (reported in Laird et al.) to portray Islam as a traditional and backward world view that has no recourse to modern western biomedicine. Islam understands the pain as both simultaneously physical and spiritual. There is in principle no necessary contradiction between the two.

Conclusion

Throughout this thesis we have attempted to show how the biomedical paradigm has come short in its ability to explain or provide an adequate framework for pain, especially in light of the anthropological and sociological studies that have highlighted pain's multidimensional nature. This multidimensional nature understands pain as a physical experience but also as an individual phenomenological experience that is tied to pain's ability to disrupt the performance of social routines and practices through which individuals' sense of identity are secured. Because pain interrupts individuals' identities it also tends to provoke broader questions of meaning, questions that often take a religious or quasi-religious nature. These studies have demonstrated that while pain indubitably has a physical dimension, it is not exhausted by this dimension. Furthermore, western biomedicine itself is not outside of culture; it mobilizes a specific cultural framework, in the words of Kleinman, that of Western materialism. Anthropological and sociological studies have further shown that in the absence of sufficiently meaningful explanations of pain, individuals tend to draw on other paradigms and frameworks which mainly derive from a religious or quasi-religious background, even if they are not overtly religious. These individuals use available cultural meanings to explain their pain and make sense of an otherwise unexplainable situation. In doing so, these individuals have realized the tremendous effect and toll that pain has taken on their bodies and identity. Most of these people accept their situation and adapt to their new lives.

However, the point of this thesis is to understand how Shia Muslims specifically make sense of their pain and suffering in the absence of meaningful medical explanation. In this research, we have explored the consequences of sudden, unexplained, and prolonged pain. As the theoretical research highlighted, Muslims were no exception to the rule. They

also employed a cultural and traditional (religious) paradigm to give meaning to their situation and pain. They also complained about the effect of pain on their body and identity and professed that even though they saw their pain as a trial, a test, as well as a result of their own “bad” deeds, they would have preferred not to have had it. However, for Muslims pain differed in the sense that it was used as a social measuring rod by its sufferers that revealed the need for more spiritual practice to attain salvation. They saw pain as a ‘gift’ from above, out of the mercy of God (as one scholar put it) so as to bring Muslims back to the right path. In this sense, Muslims differed in many aspects: they paid a lot of attention to their actions and deeds in this life. In other words self blame was a very common theme among them because they held themselves (and only themselves) as responsible for their situation. Men also differed greatly from women as they paid more attention to their inability to perform their duties and tasks which caused even more ‘social’ pain. Thus, the heightened notion of responsibility and duty were unanticipated themes that had not been originally foreseen. It is also important to note that our respondents did not reject western biomedicine in principle. In fact they expressed disappointment at medicine’s inability to provide satisfying answers. In this sense, our Muslim respondents are not unlike other religious or secular respondents in similar studies. It also raises doubts about the incompatibilities between biomedicine and Islam.

We should note that although Islam and Christianity share many similarities they differ as we have seen on their general perspective on pain. Christian religion views pain as a Godly act with which people should not interfere. The model here is the pain of Christ, thus once all biomedical avenues have been exhausted, the pain should be accepted and borne. For Islam, even though pain is seen as a mercy from God, the pain has both a function and goal. Pain serves as a measuring rod for piety and good deeds; it provides an opportunity for

self-reflection and spiritual analysis. It is a sign that not all is well. Thus it makes individuals responsible for their pain, but it also empowers them by making it clear that they have to act on a spiritual plane. Pain always has a meaning that the Muslim must endeavour to discover through religious examination. However, this does not mean that Muslims reject biomedicine. Quite to the contrary, they are encouraged to secure medical treatment for their pain. Pain exists as both a physical and spiritual fact within the Islamic worldview.

We should mention again that this thesis is in some ways moving through uncharted ground, as there exists very little (in English at least) socio-medical literature dealing with Muslims in general. Hopefully this provides as sort of impetus towards a systematic study of Muslims specifically in the field of socio-medical research. While this may not be an easy task for sociologist considering the political situation, it could serve as a new ground for expanding the sociological imagination.

Much has been learnt personally from this thesis. It has allowed the author to develop analytical writing skills; it has further allowed the author to develop a stronger sense of the nature of sociological research. In addition the experience of undertaking this research/thesis has opened the author's eyes to the importance of adopting new and competing views of the same topic. In this sense, this approach has allowed us to expand our research topic in a number of interesting fields. The author has also begun to learn to balance personal beliefs with research data. It has sometimes been hard to write things that seem at first contrary to what one believes. This research has also allowed the author to understand the distance between theory and practice and multiple ways in which phenomena are interpreted differently by individuals.

Of course, we have to admit that our research is limited as an MA thesis. And 8 interviewees do not provide the basis for a systematic and generalizing study for the Shia

Muslim population. We would have additionally liked to see how non-practicing cultural Muslims would react in this case, would they use a cultural and religious framework to make sense of their experience? In other words, is Islamic culture sufficiently robust to influence even those who do not practice to frame their experiences in religious terms? That is work for a future project.

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Appendix I

1. Meaning of life/Purpose of humans

In a few words, could you tell me what the meaning of life is according to Islam?

- Test?
- Get rewarded (heaven/hell)?
- Worship?

Could you also explain to me the purpose of humans on this earth (according to Islam)?

- Why are we here?
- What do we do?
- Where do we go after?

2. Pain

When you hear the word pain, what first come through your mind?

What did you know about pain before you pursued your Islamic studies?

- Did you ever ponder about it?
- Describe what you thought about it?
- Did you ever question yourself why?

3. Pain and Islam

What is the Islamic philosophy behind pain (and suffering)?

- Why do we feel pain? Why do we suffer?
- Is pain punishment from God?
- Atonement for sins?
- Or result of the deeds of man?

Tell me in details how Islam views pain?

- Psychology of pain?
- Physiology of pain?
- Medical pain?

Islamically speaking, is there any goal or point behind pain?

- In other words, is it an end in itself?
- Or is just a means to something beyond it?

Do you think pain brings about religiosity (or a feeling towards the existence of God)?

- If so, why is that?
- Does that feeling come about due to its mystery?
- Out of fear?
- Out of unknown reasons?
- Or do they sprout out of nature of humans?

Appendix II

1. Life in Pain

When you hear the word pain, what first comes to your mind?

Can you describe pain for me? Describe what you feel towards it, try to explain it.

Have you ever experienced extreme pain that you would term as suffering?

- Was that pain unbearable?

How would you describe this specific life-experience?

- How it felt?
- Did you think of death? (life)
- Did you think of life? (meaning)
- What did you think of your body? Did you think that you and your body were two different entities? Body alien to yourself?
- What kept going through your mind at that time?

How did you feel around friends and family?

- Vulnerable? Weak? Alienated? Baffled? stunned?
- Has your relation with them changed during that time?

Did the word WHY run across your mind during this painful experience?

- Were you able to answer it? How did you answer the WHY?

2. Life before Pain

How would you describe your life before undergoing pain?

- Did you ever think of your life in meaningful way?
- Did you ponder about death often?
- How would you describe yourself (identity)?
- What was your relation to your body? How did you view your body (as a part of yourself or separate)?

3. Life after Pain

How would describe your life after pain experience?

- Would you say pain had a positive effect?
- In what sense?
- Would you say pain had a negative effect?
- In what sense?

4. Consequences of Pain

- Do you think pain has in many ways changed your outlook on life?

- On your self?
- On your body?
- What would you attribute to pain as having changed you? In which way?

5. Making sense of pain

How do you make sense of what you have undergone right now?

- Why me? Why not someone else?
- Reproach and self-blame?

How did you start making sense of it? Thought about? Tradition/Cultural upbringing?
Advice of friends or family?