

The Social Sources of Pain, Distress and Misery: A Medical Anthropological Perspective on the Sym- bolic Bridge between Social Structure and Physiology

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Introduction¹

“...human misery has awakened, stood before you, and today demands its proper place.”

Jean Jaurès [1897] 1986:37

Medical anthropology has many subjects and many scholarly paths. I was asked to illustrate the subject on which I am presently spending my energies, and thereby to indicate the path I have traveled. During my first decade in medical anthropology I focused on three questions:

- How can we best model medicine in society so as to foster cross-cultural comparisons of medical systems?
- How do we interpret illness as cultural construct and symbolic communication?
- What practical contributions can an interpretive anthropological approach make to reform medical practice and redirect the education of health professionals?

Over the past six years my peculiar intellectual odyssey has led me to two other questions which, like the former enquiries, I have studied by means of field projects in Chinese and American societies. These more recent concerns query:

- What are the social sources of that category of human misery that we call health problems?
- And how do we study the symbolic bridge (the sociosomatic reticulum, if you will) that recursively and dialectically connects meaning, relationships, and the social structures that anchor them, on the one side, with body-mind processes, on the other?

These subjects have created, without conscious planning, what I now recognize to be a trilogy, beginning with my first book, *Patients and Healers in the Context of Culture* (1980), which canvassed the first three questions; extending to the *Social Origins of Distress and Disease* (1986 from Yale University Press) which responds to the latter two queries and also serves as the quarry from which I have mined this talk; ending with *The Illness Narratives*, a book that aspires to be an anthropological phenomenology of the experience of sickness and the work of doctoring. This trilogy takes its origin from an abiding passion that has motivated my intellectual interests since 1962: namely to rethink the purposes and fundamental nature of medicine as human science and praxis. With this personal background as an introduction, I will turn to the subject of this article.

Professor Barrington Moore has shown in his 1970 classic account of human misery that its social sources are a golden thread running through the social sciences from their inception in the Western philosophical and humanistic tradition, through the writings of Marx, Freud, Durkheim, Weber, and other early seminal contributors up to the current

period. It remains one of the few fragile strands that still links ethnographers, social survey researchers, psychometricians and clinicians, and the myriad of schools and special interests that constitute the social sciences today. Social epidemiologists, medical sociologists, social psychologists, cross-cultural psychiatrists, and members of our own field share an interest in this question (see Fiske and Shweder 1986). As in the past, we recognize, though now with massive empirical confirmation, that some categories of people -- because of class, ethnicity, caste, age, gender, or other social colorings -- are placed at greater risk to develop distress, demoralization, disease, and other forms of misery, owing in large part to these social distinctions. This insight may have little cachet at present (indeed, may be actively denied) among health and social welfare professionals in North American society, but it is for social scientists one of the undeniable social facts. The practical implications of this knowledge are potentially profound though largely latent at present. But public health application is not the subject of this paper.

Instead, I first wish to review some of the evidence for this assertion, then examine the more vexing question of how medical and other forms of human misery are socially produced (caused). I take the latter to be an especially pertinent enquiry for medical anthropological research. Finally, I will set out important questions for medical anthropology that arise from this line of analysis, questions that I am convinced make our field a potentially powerful source of theoretical contributions to anthropology generally and to the health sciences.

Now for the evidence. If we take mortality and morbidity rates into consideration, we find that these are highest world-wide in the lowest socioeconomic strata: the poor die at a higher rate and bear more sickness than do the rich or even the moderately well-off (Black 1980). Infant mortality rates, overall cancer rates, rates of diabetes and heart disease, and most other disorders (including mental illness) in North American society are highest among the poor and among Black and Hispanic ethnic groups (Boston Globe, 17 October, 1985:41). Unemployment, not biomedical tests, is the best predictor of disability rates (Stone 1984), and local conditions in the work place predict more accurately who will return to work from the disability rolls than biomedical tests (Yelin et al. 1980).

But the poor, the disadvantaged, those groups bearing the greatest discrimination and stigma also are afflicted with high rates of family breakdown, suicide, alcohol and drug abuse, crime, homicide, child injury (intentional and unintentional) -- the dark side of modernization and social change (see Hamburg 1986). Demoralization, disease, distress, despair, then, are systematically linked to social categories of persons, and that linkage subsumes physiological changes that result from what we might call the biology of human misery (Lewontin 1984). That biological underpinning makes problematic any clear line of demarcation among those forms of misery labeled "medical" and those regarded to be problems of the welfare system. The historical development of the helping professions, the cultural development of categories to label misery, and the relative social power of particular categories of persons strongly influence whether a problem is dealt with as a welfare, health, or legal problem. The designation of disability in the welfare state is not a medical decision but ultimately a political one (Stone 1984).

We know, moreover, that even when measured via the extremely superficial and crude techniques of survey research, seriously stressful life events increase and social support networks become less adequate as we descend the class ladder (Berkman 1981). Indeed, these variables, which are usually kept neatly separated in sociological and psychological research as discrete predictors, are, from an ethnographic point of view, measures of systematically interrelated aspects of the same vicious cycles that mediate the onset of acute disease, exacerbation of chronic health problems, and the construction of despair.

Once we look harder at a particular community, however, the problem is more complex. Not only do many individuals in local cultural systems who are disadvantaged and under pressure of macro-social forces not become ill or demoralized, but entire groups may not be affected as predicted on the basis of socio-economic indices. Privileged economic and social statuses, moreover, may not protect an individual from health and mental health problems.

The typical explanation for this discrepant finding is either to cite genetic factors or to trot out a long list of allegedly "independent" causal variables, any one of which is held to be a potential cause of disease and distress. The latter approach effectively isolates all variables from one another so that their systematic interrelationships are discounted. The former tends to denigrate the dialectic between gene and social environment that is crucial for many disorders, and therefore exaggerates the contribution of biological factors (Lewontin et al. 19984; Levins and Lewontin 1985). I would not discount the importance of biological basis to disease states. But I do wish to emphasize the dialectic between biological and social processes which plays such a key role in the onset of acute disorder and exacerbation of chronic illness. For this reason, I wish to suggest a different solution to this conundrum, one based on my field work and research by my colleagues in the Harvard medical anthropology group.²

Research in China and Boston: 1980-1986

At the Hunan Medical College, my wife and I studied more than 150 patients with neurasthenia who attended psychiatric and primary care clinics (Kleinman 1982, 1986 in press; Kleinman and Kleinman 1985). Neurasthenia is the most common neurosis diagnosed in China and includes patients with chronic demoralization, psychosocial distress, chronic pain and various other somatic idioms of distress. Our research disclosed that individuals from stigmatized class and family backgrounds who have major work or family problems and financial or political difficulties are overrepresented among neurasthenia patients. Their chronic illness behavior does not respond to medical interventions, but does improve when family, work, and political-economic problems are remedied. Indeed neurasthenia in China appears to be the major somatic idiom of distress for expressing and coping with these "medical" forms of distress and misery. Our research shows that it is an especially important lever in China's tightly controlled work-disability system. Psychological and biological vulnerability also played a role in predisposing certain of our patients to develop neurasthenia. A three year follow-up showed these findings to have stability over time in the chronic illness experience.

Our research in Boston, now in the data analysis phase, is an ethnography of the illness experience of 55 chronic pain patients observed over an 18 month period. This research discloses that problems in patients' local contexts (family, work, school, neighborhood, social network settings) correlate with exacerbation of symptoms and worsening of disability. This research further reveals that ethnographic interpretation provides a more discriminating assessment of influence of local context on illness behavior than do survey measures of stress and social support. Ethnographic life course review also seems to yield a more valid assessment of personality than do psychometric instruments. Findings from this study provide evidence parallel to that in our China studies implicating vicious cycles of work and family problems in socially and economically vulnerable individuals that lead to demoralization, despair and distress which in turn amplify pain, disability, help seeking and problems in clinical care. Symptoms support negotiations in these local contexts that may (but sometimes do not) improve problematic relationships.

A case from our China research should illustrate this pattern.³

Case Study

Comrade Yen is a 40 year old teacher in a rural town, intelligent, articulate, and deeply depressed. She sits immobile on the wooden stool opposite us, looking fixedly at the floor. Her black hair tied tightly in a bun behind her head is streaked with white; her handsome, high cheek-boned face is deeply lined with crow's feet radiating outward from each eye. She slowly recounts for us the story of her chronic headaches.

"There are several sources. Before the Cultural Revolution I was out-going, active, had high self-regard. As a teenager I had been secretary of the local Communist Youth League. I dreamed of a career with the Party and advanced education. My family and friends all expected great achievements. I had ambition and high goals. Then during the Cultural Revolution I was severely criticized. I had to leave my position in the Youth League. I went to the distant countryside to a very poor place.⁴ I couldn't adjust to the conditions. The work was too hard; too little to eat. Bad smells were everywhere, and nothing was clean. Terrible living conditions!"

All of this was made worse by the realization that her career aspirations were no longer tenable, and that even return to an urban environment was unlikely. The daughter of intellectuals, with several generations of professionals in the family, Comrade Yen felt deeply the lost opportunity for a university education and career in the Communist Party, sources of social mobility in China. Cut off from family and friends, and books and newspapers, yet not well-accepted, at least initially, by the peasants among whom she lived, she grew aloof and solitary. As the Cultural Revolution accelerated, she occasionally bore the brunt of self-criticism sessions. On one occasion she was denied an injection by a nurse at a rural county hospital who accused her of being a "stinking intellectual." She began to experience a change in personality. Comrade Yen felt constantly demoralized, and in place of her former optimism, she felt hopelessness generalized to all aspects of her life. Comrade Yen expected only the worst to happen. She became introverted, sensitive to what she perceived as the rejecting and criticizing eyes of peasants and cadres. She first began to depreciate her goals, then herself. Hesitant where she once had been assertive, lacking confidence where she once had radiated it, Comrade Yen regarded herself as inadequate and coped by narrowing even more her behavioral field and already limited options. She kept to herself. Eventually she obtained a post as a primary school teacher in a rural town. When her native abilities became apparent to her fellow teachers, they wished to elect her the principal. But Comrade Yen declined because she feared the responsibility and did not want to expose herself again in a situation where she might well fail and suffer further losses.

She married a native of the region who is presently a peasant but previously was a cadre in a mine. They live apart, and it is clear she prefers it this way; he resides in a distant production team, while she lives in the small commune town. They have three children, two adolescent sons who live with their father, one daughter who still lives at home with her mother. Comrade Yen is angry that her husband has not been rehabilitated and given back his post as a cadre. It is aggravating to her but her husband has given up, declaring that he will never regain his former status. This is a chronic source of frustration, another difficulty about which she feels nothing can be done.

Her third source of anguish is her daughter. "I really did not want to have her. I wanted to be alone. We already had enough children. When I was very pregnant I hit myself several times quite hard against the wall, hoping I might abort. But my husband wanted a child and I could not decide on an abortion at the hospital. Thus I blamed

myself when I gave birth to a baby girl with a withered arm. I felt I caused it."⁵

The daughter grew up to be beautiful and very bright, an outstanding student. But her mother grieved for her because of her deformity. "In China, normal people don't marry cripples. Even though she could do everything -- cook, clean, play sports -- I knew she would have trouble marrying." At this point in our interview, the patient silently cried, her gaze fixed on the cement floor beneath the table separating us. Her husband, who had accompanied her, looked much older than Comrade Yen and was wide-eyed in a provincial capital he had visited only several times before. His coarse features may have contrasted with his wife's more refined face, but he joined her in weeping openly when she continued on about their daughter:

"There is no hope for her. Even though she is one of the best students in the senior middle school, she cannot take the examination to go to the university. Her school principal and the secretary of the local branch of the Party decided that only completely healthy, normal children can take the examination. We appealed to the county authorities, but they upheld the decision. There is nothing that can be done. Our daughter will live at home and do what work she can."

There followed several minutes when the patient could not go on, but sobbed and wept. Finally she told us how she and her husband had arranged for their daughter to meet another "cripple" in a nearby town. But her daughter decided she would not marry someone else who was deformed; rather she would remain single.

Comrade Yen shared her full hopelessness with us. Often she thinks it would be preferable to be dead. Her headaches keep her to herself. She cannot face any more "stress", it is too upsetting. "My health is too uncertain. I cannot do too much. I think only of my headaches, not of the future or the past." Comrade Yen severely restricts her world. She withdraws from all but essential responsibilities. She cannot plan any outing "because of bad influences on my health: the weather, the noise, the crowds..."

Because of her feelings of inadequacy, failure, hopelessness, despair, she circumscribes her life to school and dormitory room. Only on occasional weekends does she visit her husband. Her daughter stays with her. They appear to be like two recluses, each grieving somewhat different losses. Comrade Yen's world is now that of pain: experiencing her hurt, waiting for it, fearing it, talking about it, and blaming her problems on it. It is the pain (and related complaints) that legitimizes her withdrawal at work and in family life, sanctions her isolation, her demoralization and depression. Her chronic pain is an unavailing expression of her multiple losses. Before we departed she sent us a letter:

"I feel always sad about being ill for such a long time. I feel headache, dizziness, don't like to talk, take no pleasure in things. My head and eyes feel swollen. My hair is falling out. My thinking has slowed down. Symptoms are worse when I am with others, better when I am alone. Whenever I do anything I have no confidence. I think because of the disease I have lost my youth and much time and everything. I grieve for my lost health. I must work a lot every day just like the others, but I have no hope in what lies ahead. I think there is nothing you can do."

General Implications

Other cases from China indicate a continuum of effects of macro-social and personal influences on despair and disease, sometimes with the former more determinative, in other instances with the latter the dominant causal factor. But in the vast majority of cases, including Comrade Yen, these effects of the Cultural Revolution, bad class background,

severe economic pressure, on the one side, and personality, physiological state, and genetic endowment, on the other, are mediated through the local context of relationships in work, family, social network, and community.

Much the same finding emerges from our study of chronic pain patients in Boston. Exacerbation of symptoms (back pain, sciatica, headaches) and worsening of functional impairment oscillate with periods of quiescence and dampening of bodily discomfort and personal distress. Periods of amplification are associated with worsening of existing problems in the local social setting or the onset of new interpersonal problems. Initial onset of trajectories of pain discloses the same dynamic interconnection between macro-social forces, body-self processes, and local contexts of power that we have described in our Chinese subjects (see Kleinman and Kleinman 1985).

These studies show that where vicious local cycles of powerlessness, oppression, loss, threat and inescapable social dilemmas exist, there individuals who are already at risk owing to macro-social economic and cultural pressures are placed at even greater risk for demoralization, despair, and disorder. Biological factors play a role in increasing risk and determining the kind of misery. But the nexus between social structure and physiology, social relationships and psychological reactions is the local context of legitimacy, signification, and power.

Thus, anthropological analysis points to a double dialectic central to human misery. There is the dynamic interrelationship between changing macro-social structures *and* micro-social context. Here the former places great pressure on the latter and through it on particular categories of individuals. But the local social system recursively influences the vector and cachet of macro-social influence, shielding some groups of persons, mitigating the pressure on others, placing yet others in positions of vulnerability and risk. The local social context, in turn, is dialectically interrelated with psychobiological processes. This double, sociodynamic dialectic is the symbolic bridge that anchors biology in the human experience and makes the social order a part of physiological-psychological reactions.

This conceptual framework, so obvious to many medical anthropologists, is regarded as *imaginative* by our colleagues in other fields. The integrative anthropological insight into systematic interrelationship between society and physiology runs counter to the major models in medicine, public health and social-behavioral sciences. Although there is increasing discomfort with dualistic, reductionist perspectives (Levins and Lewontin 1985), there is great uncertainty about how to conduct research in this area. A key focus, then, in medical anthropological research should be the development of substantial descriptive and comparative projects, even of preventive and therapeutic studies in collaboration with clinicians and public health researchers, to better establish these connections, to demonstrate their health and mental health implications, and to show that local interventions combined with appropriate macro-social change can be effective in relieving some forms of human misery while preventing others. This is a very difficult but extremely exciting agenda for research. It requires interdisciplinary collaboration and the combining of anthropological and epidemiological research techniques, ethnographic with survey and clinical methodologies, field work with policy analysis, and lobbying for political change. This agenda offers an unusual opportunity to rethink theory basic to this subject: e.g., a critical review of the now dominant, yet embarrassingly simplistic psychological model of stress, of the translation of social development theory into the impoverished conceptual framework of international health, of a critique of the limitations of political economy models of disability that fail to take into account local meanings and relationships. It encourages applied programs in which the anthropology of human misery leads to practical projects to respond to corrigible social problems, and to redefine other social problems as potentially corrigible. Here medicalization of social problems requires a more nuanced assessment to determine those

problems that are trivialized and masked when medicalized, and those for which effective social intervention may be legitimated only under a medical label.

Although many research issues constitute medical anthropology's research agenda, I would claim a high priority for this one because it is so potentially important both to the development of the discipline itself and to the place of medical anthropology within anthropology and the health sciences. That is to say, the study of how local contexts mediate the effect of large-scale social forces on individual experience is a grand intellectual theme that can move medical anthropology from the margins of current theoretical debates in the social sciences to the center of one of the perennially salient questions in social science theory -- the relationship of culture and biology -- that is particularly significant today. From a methodological perspective, this academic focus encourages highly original integrations of interpretive ethnographic, sociolinguistic, survey, and psychobiological measurements. Moreover, this orientation anchors anthropological theory in pressing social concerns worldwide.

As a result medical anthropology (that applied rump of anthropology looked down upon by our colleagues as a poor relation) will become a leading edge of theory building and significant research. For the health sciences, this orientation is equally important. It is a direct challenge to the romantic biologism and revanchist ideology of technological solutions to social problems. It is an agenda that forces health science research and education programs to come to terms with the immense importance of the social sources of distress and disease and with the often artificial boundaries between the different forms of human misery. I am convinced in the long run such an agenda could lead to a thorough rethinking of medicine as a human enterprise. But this agenda also requires a change in the way we do research in the anthropology of sickness. Most of our research avoids the interdisciplinary questions of causality that must be at the very center of concern in the orientation I am promulgating. Nonetheless, there are many ways of doing research on the social sources of human misery and their remedies, and I am confident that if this topic becomes a core theme it will receive just as rich and variegated analyses as anthropologists have provided for the study of illness meanings. Now what we need are major projects that will create a new anthropological epidemiology and anthropologically informed medicine (see, for example, Manson et al. 1985; Good et al. 1985; Rubel et al. 1985; Comaroff 1985; Janes et al., 1987). The future, like the present, will be difficult. The obstacles are substantial (Kleinman 1986). But there is the looming possibility that our era is becoming witness to a radical breakthrough in the very way we conceive of the nexus between biology and culture, sickness and society. Medical anthropology could be in the vanguard of this paradigm shift.

Notes

1. This paper was the subject of a talk delivered at the 30th Annual Meeting of the Kroeber Anthropological Society during the plenary session on "The Anthropology of Sickness," Department of Anthropology, University of California, Berkeley, March 8, 1986. Much of the material covered in this paper is the result of research projects my wife (Joan Kleinman) and I have conducted over the past six years in the People's Republic of China (funded by the National Academy of Sciences, the Social Science Research Council and the Milton Fund, Harvard University) and in the Boston area (funded by the National Science Foundation) with patients suffering from depression, chronic pain, neurasthenia, and other chronic medical conditions. A fuller account of these studies is to be found in my volume, *Social Origins of Distress and Disease*, Yale University Press, 1986.

2. As of the writing of this paper, the group consists of Joan Kleinman, Byron Good, Mary Jo Good, Peter Guarnaccia, Thomas Csordas, Harvey Bidwell, Mitchell Weiss, Pablo Farias, Paul Brodwin, Terry O'Neill.
3. This case is taken from Kleinman and Kleinman (1985) and Kleinman (1986, in press). Names and certain other details have been changed to protect the anonymity of the patient.
4. During the Great Proletarian Cultural Revolution (1966-1976), urban youth were rusticated to distant and usually impoverished rural areas for reeducation through physical labor and learning from peasants.
5. From a biomedical point of view, it is extremely unlikely that Mrs. Yen could have caused her daughter's congenital deformity.

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