

# Acute Pain Infliction as Therapy\*

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**ABSTRACT** This essay begins with the observation that acute pain infliction is central to the therapeutic process in Chinese acupuncture. The common biomedical explanation for this is ‘counter-irritation’, yet this essay suggests that an acute pain event can cause a bodily felt, immediate social connectedness between patient and healer, which might be therapeutic. Since acute pain can effectively be communicated to others by non-verbal means, it has the capacity to break down habitual boundaries between persons, decentre both the person in pain and those in his or her close vicinity and enable instantaneous trans-individual communication. The collective presence of communally felt pain makes possible an embodied experience of sociality. Based on an anthropological definition of acute versus chronic pain, the essay suggests that life cycle events typically structure intrinsically (or potentially) painful situations into acute pain events. Concluding, this essay suggests that in medicalised societies the decline of acute pain events in life cycle rituals has led to the silent rise of chronic pain syndromes.

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## An ethnographic account of *de qi* in acupuncture treatment

Pain infliction is central to the therapeutic process in acupuncture. Such treatment usually involves needling between four and ten acupuncture points (or loci) that are located at clearly defined positions on the body surface. In medical practice, the acupuncturist who has memorized their positions finds their precise location by tapping in their vicinity on to the patient’s skin; points are often in grooves or by the side of a protuberant bone structure. Then, after having determined the precise place, he or she presses on to the skin with one hand, and with a skilful movement, which should avoid causing pain, inserts the needle with the other. Nowadays, needles are usually made of steel; although they are fine, they are not easily bent. Once inserted, they should not be left sticking in the skin, but doctors should work on them, particularly if a condition is treated that involves supplementing (*bu*) or discharging (*xie*) *qi*.<sup>1</sup> The acupuncturist may push or pull the needles at different velocities (*xuji buxiefa*), shift and wave them (*yiya buxiefa*), or twirl and rotate them (*nianzhuan buxiefa*), apart from engaging in a wide range of other techniques (Lu et al. 1987).

When the doctor inserts the needle and works on it, there is a moment of slight tension, stillness, and concentration between doctor and patient, which finally is dissolved by the patient exclaiming: ‘Dele, dele – I got it [the *qi*]’. This is the moment of acute pain infliction: often synchronically the patient shivers slightly or catches a breath of air and the doctor sighs with relief or sometimes grunts with satisfaction (Hsu 1993/94). For the needling to be effective, I was told, the patient has to feel pain. The pain is of a particular kind, it should not hurt in the sense of *tong* (to hurt). Rather, the pain experiences that needling is supposed to evoke are *suan*, which means ‘sour’

or 'sore', or *ma*, which refers to a prickly and tingling feeling, or *zhang*, which means 'to swell' and 'to expand', and may refer to a feeling of warmth and heat expanding from the needled point. This is taken as a sign that 'one has got *qi*' (*de qi*). Doctors are also meant to feel in their finger tips whether or not one gets *qi*, and some explained, in accordance with accounts from the medical archive (cited in for example Qiu and Zhang 1985:156), that it felt like a fish that snaps the hook of an angler.

I carried out ethnographic fieldwork in Kunming, the capital of Yunnan province, in the People's Republic of China, in 1988-89, as a student of acupuncture at the Yunnan Traditional Chinese Medicine College, where I learnt Chinese medicine in Chinese with Chinese classmates. The first six months I spent in the class room learning the basics of Chinese medical theory (Hsu 1999: chapter 6), but from the second semester onwards, I spent three mornings a week on the acupuncture ward. I engaged in what I later called 'participant experience' and set out to gain competence in the esoteric knowledge and practice I planned to write about as an anthropologist. I believed that by acquiring the embodied skill myself I would gain a fuller understanding of it (Hsu forthcoming).

The method of 'participant experience' lent itself well to the study of touch that evokes pain, for not only was I learning the refined methods of inflicting pain on others with fine needles, I also experienced this sort of pain infliction on myself. Acupuncture represents a highly sophisticated technique, which works our largest sensory organ, the skin, for healing purposes by, as argued in this essay, generating an enhanced feeling of sociality. It is always difficult to communicate one's sensory experiences (as will be discussed below), and the fieldwork method of 'participant experience', which involved touching and being touched, made possible an ethnography that may escape the participant observer. Since acupuncture attends to the sensory vastness of the skin, an ethnographer's insights are in the course of learning this technique much enhanced by him- or herself engaging in the processes of needling and being needled.

When I was needled the first time (during an undergraduate fieldwork period in Chengdu in March 1986), I realised that the needle did not only inflict a locally sensed pain but also affected my breathing. I had attended the acupuncture clinic despite a cold and a blocked nose, and was constantly sniffing. My teacher, slightly irritated by this, suggested treating me with acupuncture. I had no idea that acupuncture was effective for treating colds, but why not give it a try? He sat me on a stool, had me lower my head, pushed my hair from my nape, and skilfully inserted two needles into the two loci called *fengchi*. This instantly took my breath and I gasped for air. The pain was excruciating, and I asked my teacher to take out the needles. He explained that treatment consisted of bearing them for twenty minutes, and assured me the pain would eventually diminish. By then I had noticed that I had started to breathe deeply. At first, I thought this was a body reflex to reduce the pain. However, after some minutes, which seemed to me an eternity, it was impossible to tolerate the pain any further and I insisted on having the needles removed. My nose was indeed cleared, albeit only for a short while, an hour or so.

Despite this rather dramatic experience, I sometimes took acupuncture treatment in later years. It was never as drastic as the first time. When needled, it felt more like a tingling or prickling, which could be quite pleasant, and, sometimes, particularly

in Europe, I barely could feel the needles. Nevertheless, I variously observed myself changing rhythm and depth of breathing. Incidentally, Chinese acupuncturists say that *de qi* affects *qi* (which has connotations of ‘breath’), and its movements.

The concept *de qi* (to get *qi*) explains differences in therapeutic effectiveness after delivery of the same treatment. When two doctors needle exactly the same acupuncture loci but one is effective, and the other not, the technique of latter’s hand (*shoufa*) is to blame. A good *shoufa* brings about the arrival of *qi*. In contemporary acupuncture, *qi* is thought to flow in channels (*jingluo*) and one works on the needle to effect an arrival of *qi*. Once this is achieved, one can regulate the flow of *qi*.

While the acupuncturist makes ‘getting *qi*’ responsible for efficacious treatment, the anthropologist puzzles over the social significance of this form of acute pain infliction during the therapeutic process. Incidentally, the same idiom, *de qi*, or rather, a closely related expression, *qi zhi* (*qi* has arrived) is found in self-cultivation and medical manuscript texts that are two thousand years old. Vivienne Lo renders a passage in a text on the sexual arts called ‘Uniting of Yin and Yang’ (*He yin yang*) as follows:

Stab upwards but do not penetrate in order to stimulate *qi*, when the *qi* arrives (*qi zhi*), penetrate deeply and thrust upward in order to distribute the heat. Now once again withdraw so as not to cause its *qi* to dissipate and for her to become exhausted (2001:43).

Evidently, *qi zhi* refers in this text to the climax of sexual union, but the same expression was used in the context of acupuncture treatment already in antiquity (Ren 1986:256). Accordingly, *qi zhi* and *de qi* must refer to the climax of needling in acupuncture treatment. This climax, one would assume, is in one context marked by extreme pleasure (although the above text on the sexual arts does not explicitly state this), while the words *suan*, *ma*, *zhang* are generally used to express slightly painful experiences. One may wonder why the same idiom *qi zhi* / *de qi* denotes in one context extreme pleasure and in the other acute pain, and is reminded of how sadomasochists collapse the distinction between the two:

In my experience, practitioners consistently report that S/M is not about pain, but pleasure. The appeal, they say, is that it collapses the distinction between the two: both in the end are ‘sensation’ and there is no such thing as good or bad sensation (Rosenblatt 1997:312).

It seems to me that the idiom *qi zhi* or *de qi* refers to what S/M practitioners call a ‘sensation’, which implies neither pain nor pleasure. The idiom seems to designate a moment of climaxing not only in sexual union but also in the therapeutic moment of synchronous action. In both cases, two persons are involved and after climaxing in pleasure or pain, there follows relaxation, or a catching of breath.

Another colleague, Gry Sagli, who works on Chinese medicine and its reception in Norway, quite independently of other researchers’ interest in *qi zhi* and *de qi*, was also intrigued by the concept and extensively discussed it in her PhD thesis (Sagli 2003:215-218). She studied the reception of Chinese medical concepts among Norwegian practitioners, and their patients, and how in the course of cultural transmission these concepts and corresponding practices are transformed. She pointed out a wide

spectrum of different ways of relating to Chinese medical concepts, which ranged from the one extreme of denying them any reality to the other of their unquestioned acceptance. The channels (*jingluo*), for instance, are entities of Chinese medical theory for which no bio-physiological explanation has been found. *Qi* and *xue* (blood) are supposed to flow through these channels, and most acupuncture loci are found along them. While doing fieldwork in China, I immersed myself so much into my studies that I sometimes felt much the same as my colleagues, who were completely convinced of their reality. It was only a matter of time, we agreed, before biomedical research would prove their existence. Needless to say, once I returned to Britain, my belief in the reality of these channels quickly dissipated. It is therefore not surprising that many Norwegians have the same critical attitude to the channels as I experienced for myself among the people in Britain. In a European setting, what needs to be explained is why people start believing in the reality of the channels.

Sagli made the interesting observation that some of the people she worked with would sense a pulling along the channels, once they were needled, and that those who had this 'sensation' were more inclined to believe in the reality of these channels. This is plausible. Yet Sagli also found that patients who experienced *de qi* readily accepted the reality of the channels. This surprised her. After all, *de qi* was not felt along a channel but only in a particular point. How is it possible that acute pain infliction can affect one's perception and cognition? Why should such acute pain experience facilitate acceptance of new concepts? Is it that pain is 'real', and the reality of pain is transposed onto the concepts that predicted the experience of this reality? Or, is it that this sort of pain infliction opens up the person to all kinds of new ideas?

A note of caution is necessary in this context: acupuncture treatment (*zhenjiu*) that involves *de qi* is not to be confused with acupuncture analgesia (*zhenjiu mazui*), which is a modern invention that became known and was instantly widely implemented during the Great Leap Forward in the late 1950s (Zhang 1989). The modern invention of acupuncture analgesia was used for pain suppression during minor surgical interventions, as for instance thyroidectomy. Acupuncture analgesia surgery was performed in operation theatres that an audience of often foreign visitors observed, from a bird-eye's view, standing in a gallery behind glass. This audience of foreigners was meant to be persuaded that not merely acupuncture analgesia, but any Chinese medical treatment was effective.

The confusion between the two rationales of therapy was perhaps intentional: it is an irony of history that a 'modern' invention, acupuncture analgesia, was used for proving the usefulness of an ancient medical practice, 'traditional' Chinese medicine and 'traditional' acupuncture (Hsu 1995, 1996). Acupuncture analgesia, although barely practised in China anymore (fieldwork 1988-89), is nowadays respected by Western biomedical professionals as being effective in about thirty per cent of pain management cases. Certain endorphins are released by needle insertion and this relieves pain and/or entirely suppresses it (for example Pomeranz 1996).

The pain researchers Ronald Melzack and Patrick Wall (1996:236-40), who also discuss 'traditional' medical techniques such as cupping, cauterisation and acupuncture, suggest that these techniques treat pain by means of pain infliction, so-called 'counter-irritation'. The concept 'counter-irritation' may partly explain therapeutic

success, but it cannot possibly explain it entirely. Acupuncture, for instance, is not only used for managing pain but also for treating such disparate disorders as common colds, fevers, coughs, digestive problems, irregular menses, oedema and other swellings, and many more. In those cases, one cannot take recourse to the idea of 'counter-irritation'. Rather, as argued below, acute pain inflictions may be effective in that they generate physical, emotional and cognitive dispositions in the patient which have the potential to enhance, or even effect, healing.

### **Acute pain infliction as therapy**

The question that arises here is: how can acute pain infliction be therapeutic? Above, the concept of *de qi* and the therapeutic centrality of acute pain infliction for Chinese acupuncture treatment was discussed. In what follows, two further ethnographic examples are given that mention pain infliction during therapy; one is from New Guinea, the other from Namibia. A third observation from Nepal suggests that acute pain infliction causes so-called 'presence' which is thought to be therapeutic.

In his most recent book *A Failure of Treatment*, Gilbert Lewis (1999) describes how among the Gnaou of New Guinea a capable and well-respected man, Dauwaras, suddenly lost control over his knees and fell. After he rose, he fell again and injured himself. What appeared to be a seemingly harmless stumbling was in fact a terminal disease. Among the Gnaou, a man who considers himself seriously ill will retreat into the darkness of his hut, cover himself with dirt and impose a long list of food taboos on to himself for avoiding the attention of the spirits he thinks could harm him. This is what Dauwaras eventually did. His kin and neighbours suspected he had been hit by the spirit Malyi, and consequently performed the great ritual of Malyi in many rites, which were held at intervals throughout weeks if not months. Yet the ritual could not restore Dauwaras' health, and in the end he died.

It is impossible to communicate Lewis' moving account of Dauwaras' illness here, and I will draw attention only to a minor detail which concerns the initial treatment of Dauwaras' knee. This is to rub nettles on to the knee. Dauwaras' knee is repeatedly treated with nettle massage. Why nettle massage? From a biomedical viewpoint one could say that this massage enlivens blood circulation or one could speak of a case of pain management through 'counter-irritation', but what about the social aspects of this practice? Noteworthy in this context is the cross-cultural similarity between the stinging of the nettles in the Gnaou context and the tingling of the needles in the Chinese one, processes that both are considered to instigate recovery and can be regarded as some form of acute pain infliction.

Among the !Kung in the Kalahari desert of Namibia it is not primarily the sick person but the person who acts as healer who experiences acute pain during a healing session, and the sessions climax in a moment where pain is inflicted on everyone present. These healing sessions are generally held at night. The sick person lies beside the fire around which the community gathers. People sing and sing, rhythmically swinging and clapping their hands, while one, two, several among them are overcome by *num*, which as Richard Katz (1982:94) explains, is the primary force of their universe.

Those overcome by *num* are in a state of *kia*. One could speak of ‘trance’, although Katz prefers not to use the term because he considers it too vague; it refers to very different ‘states of altered consciousness’, such as spirit possession, hypnosis, meditative states, and many more. Rather than using terms like ‘trance’, or even worse, implicitly normative notions like ‘altered states of consciousness’, he advocates detailed description of how these states are experienced. This is how a !Kung healer describes *kia*: ‘When I pick up *num*, it explodes and throws me up in the air, I enter heaven and then fall down. I open up; I burst open, like a ripe pod’ (Katz 1982:44).

In this process of opening up, which notably invokes a botanical metaphor, fear and acute pain can sometimes arise. A healer comments on his first experience of *num*: ‘I was very surprised when *num* came to me. It made me cry out in pain’ (ibid.:97). The pain is caused by invisible arrows, which are felt in the *gebesi*, the centre of the stomach: ‘In *kia*, around your neck and around your belly you feel tiny needles and thorns which prick you. Then your front spine and your back spine are pricked with these thorns. Your *gebesi* tightens into a balled fist. Your breathing stops (ibid.:46).’

In this state of *kia* it is important to pull – to pull and pull – the illness out of the sick person, and to negotiate with the spirits by shouting loudly into the air. It is interesting to note that pain affects one’s perceptual and cognitive faculties and alters them; or, as some put it, even enhances them. One becomes capable of ‘seeing’: ‘As a healer in *kia*, you see everybody. You see that the insides of well people are fine. You see the insides of the one the spirits are trying to kill, and you go there. Then you see the spirits and drive them away’ (ibid.:106). One notices again that pain affects the cognitive faculties. It is a pain that healers experience in a state of exaltation. However, in the moment when the illness is pulled out of the sick person’s body, acute pain is inflicted on him or her and everyone else through ear-piercing cries and shrieks:

The pain involved in the boiling of the healers’ *num*, in the putting of the *num* in the one being healed, in the drawing of the other’s sickness into their own body, and in the violent shaking of that sickness out from their body is acknowledged by the healers by crying, wailing, moaning, and shrieking. They punctuate and accent their healing with these sometimes ear-shattering sounds. As the breath comes with more difficulty, until they are rasping and gasping, the healers howl the characteristic *kowhedili* shriek, which sounds something like ‘Xaiiiiiii! Kow-ha-di-di-di-di!’, and usually accompanies the pulling out of the sickness (ibid.:108).

The *kowhedili* shriek is ear-splitting both for the healers and the patient; and they experience it simultaneously. We observe again that acute pain infliction forms an integral part of the treatment, and to a certain extent the climax of the treatment. The question I ask is: how can such pain infliction be therapeutic? What do the disparate experiences of *de qi* in Chinese acupuncture, a nettle massage among the Gnaoua, and the *kowhedili* shriek in !Kung healing séances have in common?

## Acute pain and presence

The article called 'Presence' gives a hint, although its author, Robert Desjarlais (1996), does not speak of acute pain in his description of a shamanic ritual and its effects on a woman who suffers from soul loss. Desjarlais explores which aspects of the shamanic ritual make it into a treatment that is effective. He points to odours, colours, drum and gong, which are supposed to bring back the soul of the woman, and thereby lift her out of her apathetic state. Other anthropologists may have analysed the words the shaman sang, but Desjarlais is primarily interested in the patient's 'embodied experience'. The aesthetics of the ritual attracts the attentiveness of the woman, which, as Desjarlais puts it, is a 'sensory attentiveness':

For healing to be effective, [the shaman] Meme must alter the sensory grounds of a spiritless body. How does he do so? Our findings suggest that a less cerebral model than those noted above can account for Yolmo spirit-callings: Meme tries to change how a person feels by altering the sensory stimuli around that person. His cacophony of music, taste, sight, touch, and wild, tactile images activates the senses and the imagination. This activation can 'wake up' a person, prompt new sensibilities, and so reform the cognitive and perceptual faculties that, in large part, make up a person (1996:160).

Thomas Csordas (1993), who also takes a phenomenological approach to healing, comes to a similar result in his study of spiritual healing and alternative medicine. In his terms, the basis of alternative medicine's efficacy can be found in so-called 'somatic modes of attention'. Alternative medicine is often directed at eliciting such embodied attentiveness, an attentiveness that involves the person as whole, and does not appeal to the will and the intellect only.

Desjarlais and Csordas provide an answer for explaining the above observations of acute pain infliction during therapy: acute pain evokes 'presence' and alerts one's 'sensory attentiveness'. Elaine Scarry's often cited phrase comes to mind: 'The most crucial fact about pain is its presentness' (Scarry 1985:9).

When Scarry speaks of 'presentness', she refers to the presence of pain in the individual who experiences it. This essay, however, stresses that acute pain causes a sense of presence not only in the one in pain but also in those in his or her immediate vicinity. Scarry, who studied the pain of torture victims, and medical anthropologists, who worked with chronic pain patients, have emphasized that pain is hard to put into words and that chronic pain alienates the person from the environment, to the effect that 'After a While No One Believes You' (Jackson 1992). The point made in this last mentioned essay is that this does not apply to acute pain. In contrast to chronic pain, acute pain is easily, rapidly, and extremely efficiently communicated from one to the other. No words are needed.

In the therapeutic process, the presence caused by acute pain infliction can be understood as an alertness that opens up the patient to a potentially positive input from the social environment, and possibly, it is this directly felt social connectedness that is therapeutic. This becomes particularly obvious as one widens the focus of analysis, for not only the patient but also everyone else in close vicinity is instantly affected by

this pain event, in particular the therapist. A shriek of shock, one's contraction of the face, or a sudden bodily collapse have an instant effect on whoever is nearby. Friend or foe will instantly turn to the person in pain, with great attentiveness.

In the moment of an acute pain event it is as though the boundaries between the I and the you are broken down, for both you and I are completely overwhelmed by the pain event. The small finger is caught in the door: suddenly it is the small finger that is in the centre of the world, both for the one in pain as well as for those in his or her immediate vicinity. Acute pain is thus a state of being where the habitual centre of the ego is shaken and displaced – into the small finger, for instance – it decentres and thereby opens up the person beyond the habitual boundaries and limitations (Hsu 1993/94:70-1). Acute pain is acute for both the person in pain and those surrounding him or her, and it thus generates synchronicity, a situation in which all participants involved are acutely aware of only one single event and turn their full attention to it.

### **Acute pain and the embodied experience of sociality**

The argument put forth here is that acute pain infliction can represent a crucial phase in the therapeutic process, not least because an individual's sensory experience of acute pain is eminently social. This argument builds on two premises. The first is that acute pain can be differentiated from chronic pain (see below); the second that acute pain experiences are not only essential for the biological survival of the individual, but also for building up and reinforcing social cohesion between individuals. Although the anthropological literature has not emphasized the latter much, pain is intrinsic to life cycle events, and the latter are known to enhance social bonding within a group. The acute pain event can thus be viewed as a trigger for an embodied experience of sociality and may for this reason be central both to rites of passage and the above therapeutic practices.

The common distinction between acute and chronic pain is a biomedical one (Sternbach 1984), yet it is also an experiential one (see below). From a biologist's viewpoint, acute pain has the function of promoting survival, this in stark contrast to chronic pain which has no biological function at all. Acute pain is usually thought of as a 'warning signal' of impending tissue damage though it also signals a need-state for rest and reconvalescence of already damaged tissue; 'pain as warning signal' and 'pain for stillness' both enhance survival. People with congenital insensitivity to pain therefore generally have a considerably shortened life expectancy (Melzack and Wall 1996:3-7).

An anthropologist, however, is guided by socially structured temporalities and will differentiate acute from chronic pain accordingly (for a detailed anthropological definition of acute versus chronic pain, see below). Acute pain not only has a biological survival function for the individual, but, as argued here, it also has an eminently social potential for enhancing a sense of togetherness between individuals and for making real social relatedness. In other words, the sensory experience of acute pain is essential to community building. It is the cross-culturally observed disposition of

human beings to respond instantly to an acute pain event that makes possible the intense experience of commonality, even if only for a brief moment.

It may not be insignificant that acute pain is a concomitant aspect of several life cycle events, birth and death most prominently. In those cases, the labour pain of the mother giving birth and the grief of those who are bereft are primarily in our awareness, although the newborn child, who cries upon entry into the world, and the dying person anticipating death may also experience pain. The life cycle event of marriage is usually marked by strong emotions of love and great joy, even though it often involves pain of separation, for instance, of the bride leaving her family; and in Muslim contexts, the defloration rite can be very painful for the bride and sometimes apparently also the groom. Likewise, the life cycle event of becoming adult in many societies is marked by joy, once the initiates return from seclusion into the village. Yet this process of becoming adult may also consist of a period of intentional pain infliction on the initiates.

Pierre Clastres (1973) asked why the initiation rites he studied were marked by enormous pain infliction, and in an essay – that comes close to poetics – he links the society's laws to the script, the script to the body, the body to torture, torture to memory, and memory to the laws of society. The article suggests that the laws of society are by means of pain inscribed in the individual's body.

Put more prosaically, one wonders whether Clastres implied that pain infliction enhances the learning process and facilitates cognitive acceptance of new ideas. The proverb 'once bitten, twice shy', as many others, would suggest that pain is didactic. Indeed, this seems an idea deeply entrenched in Judaeo-Christian thought, and has been subject to much literary exploration in philosophy and theology (for example Wriedt 1988).<sup>2</sup> The etymology of the word pain is poena, punishment. Is it god's punishment that teaches one how to alter one's ways of life? Job comes to mind... it is a Judaeo-Christian belief that god is known only through the experience of suffering, be it the suffering he inflicts on Job (and humankind) or his own suffering at the cross. Accordingly, it may be no more than a culture-specific myth that suffering purifies, is spiritually enlightening, and deepens a person. Proverbs suggesting that pain is didactic may reflect a Judaeo-Christian conviction rather than a social or biological fact.

Correlations between pain and learning are not as straightforward as the above proverbs would suggest. Experiments in ethology have shown that doves learn more quickly if, rather than being punished when failing a task (for example by being hit with painful electro-shocks), their behaviour is positively reinforced when they fulfil the required task successfully (for example by being given extra grains). It is thus uncertain whether punishment is always didactic and whether pain infliction actually enhances learning. Clastres' 'inscription of the laws of society on individual bodies' is therefore best considered a learning process achieved other than through the pain of punishment.

In this context, Seremetakis' research comes to mind. Although she speaks of funerals, her observation with regard to collectively felt grief may help explain why pain is inflicted on the groups of young men and women who undergo initiation rites. She states: 'It [pain] is a concept that synthesizes bodily and psychic experience; despite its profound individual ramifications, pain, particularly in Greek society,

mobilizes trans-individual systems of communication, meaning, and value (Seremetakis 1998:151).’

In other words, the group experience of individually felt acute pain triggers the group experience as one body, experienced as such emotionally and physically. Boundaries between individuals break down, and a state of trans-individual fluidity is experienced. This state may well affect an individual’s cognitive and affective faculties, an experience that due to its intensity may have long-lasting transformative effects.

Clastres and Seremetakis both emphasize the trans-individual fluidity between individuals who themselves are in pain. This essay goes a step further based on the observation that human beings generally are affected by another person’s acute pain, even if involuntarily (some may avoid the person in pain for this very reason). The essay points out that the pain event captivates the attentiveness of both the one experiencing pain and the other who, as human being, is instantaneously affected by another’s acute pain. One could speak of ‘instinctive’ or ‘innate’ predispositions to do so, but such ill-defined concepts would lead into a minefield of controversy. The fieldwork methods of the social anthropologist merely allow the observation that an acute pain event usually tends to be at the centre of the attention of all persons present.

To summarise, instead of taking recourse to the biomedical concept of ‘counter-irritation’ for explaining why acute pain infliction can be therapeutic, this essay likens the pain experience evoked by certain treatment methods to the trans-individual experience of acute pain in life cycle events. Rather than viewing Chinese acupuncture treatment (or Gnau nettle massage) as an example that involves an individual’s pain event only, the essay suggests that the distinctive pain event caused by needling (and also nettle massaging) affects at least two persons, as does the *kowhedili* shriek in the !Kung healing dance. Accordingly, these treatment events should be viewed as social events that involve, much like life cycle events, a trans-individual or communal experience of presence, alertness, synchronicity.

To say that pain in life cycle events is ‘communally’ experienced need not mean that everyone present was affected equally by pain. Pain in a life cycle event may affect participants to different degrees in different ways (just as it does in a healing séance). Sometimes, one person may feel and express pain more intensely than everyone else. During fieldwork in Kunming, for instance, at a funeral held by the parents who had lost their only child, the silence of grief in the crowd was beginning to become unbearable when the best friend of the bereaved father, a much respected adult man in his late forties, started to wail in a deep heart-rendering voice. This one individual’s pain expressed and shaped the pain event for everyone present.

Certainly life cycle events are often also accompanied by strong emotions, while sessions at the acupuncturist’s may not be as emotionally laden. Yet, it would be wrong to believe that medical treatment occurs in an emotional vacuum. The combination of a heightened emotionality and acutely felt pain allow for an all-encompassing embodied experience; a physically and emotionally felt ‘sensory attentiveness’ may well be integral to any effective social bonding. The acute pain event in the healing process, as well as in the ritual staged for coming to terms with a new life situation, may enhance one’s sense of trust both in oneself and in the other, precisely

through such all-encompassing emotionally felt and physically experienced forms of sociality.

This understanding of acute pain, which in Seremetakis' words, 'mobilizes trans-individual systems of communication, meaning, and value' (1998:151) emphasizes that the intensity of the individually felt acute pain breaks down habitual boundaries, carries individuals away from their habitual focus on themselves, and makes possible the experience of an intense feeling of commonality. However, it directly contradicts Scarry's frequently quoted and well-known statement: 'To have great pain is to have certainty, to hear that another has pain is to have doubt' (1985:7).

Admittedly, Scarry's statement is taken out of context here, and no doubt, Scarry is right to say this of heavily traumatised torture victims who were exposed to repeated and chronic pain inflictions in the torture chamber and struggle with their rehabilitation into 'normal' life, after having been pushed to the limits of their existence. The juxtaposition of the contradictory quotes by Seremetakis and Scarry on 'pain' raises the question, however, as to whether it is justified to use the one word 'pain' to refer to a wide variety of different 'pain' experiences.

## **Pain and pain**

Above, I contrasted the pain experience of a torture victim with that of wailing kin over the death of a beloved. The former, Scarry says, alienates the individual from the group, the latter, Seremetakis maintains, mobilizes trans-individual systems of communication. There is one word, 'pain', for these very different life experiences. Are we speaking of the same phenomenon? Indeed, the term 'pain' essentialises most varied phenomena of lived experience:

Sunburn, an insect bite, ... surgical operations, beating children for educational purposes, having eaten too much, rape, ... hearing a dentist's drill, ... fire walking, lumbago. ... flagellation in order to reach states of altered consciousness, et cetera. (Hadolt 2000:20).

One wonders what these different experiences have in common. In Unani Tibb, there are several terms that delimit a wide range of pain experiences (Pugh 1991). They are in translation the cold contractive 'catching' pain or the hot contractive 'pinching' and 'gripping' pain that is typical of stomach aches. Stomach aches can also be 'piercing', as can be painful feelings in chest and throat; all three can also be said to be 'burning'. The skin in pain feels 'stinging' or 'pricking', the head 'splitting' or 'bursting', and limbs and bones, if in pain, feel 'breaking'. Unspecified pain can furthermore be 'throbbing' or 'shooting'/'radiating'. In biomedicine, the McGill questionnaire lists over seventy adjectives for describing pain, from 'splitting', 'flickering', 'throbbing', 'stabbing', 'sharp', to 'dull', 'sore', and 'itchy' (Melzack and Wall 1996:40). If the insiders' words for describing pain are so varied, how can an outside observer use just one single word 'pain' as though it referred to one experiential datum?

An English acupuncturist comes to mind, who vehemently responded to my suggestion that in acupuncture treatment *suan*, *ma*, and *zhang* designate experiences of

acute pain (London, November 2004). ‘No’, she exclaimed, ‘the pricking that the needle inflicts on the patient is not pain!’ Indeed, the word for ‘pain’ in Chinese is *tong*, not *suan*, *ma* or *zhang*. In modern Chinese, the term *tong* has a similar semantic field as pain in English – it often designates primarily physical pain and can also refer to primarily emotional pain – although it has a different etymology (that is *tong* is not cognate to punishment etymologically). Having said this, needling can also hurt in the sense of *tong*, and if it does so, the acupuncturist is considered unskilled.

So, after all, is *suan*, *ma* or *zhang* a quality of acute pain, and how does it differ from *tong*? It is notoriously difficult to talk about sensory experiences for how can I know that you feel like I do when I, or you, say I feel pain or pleasure. In order to overcome the difficulty of communicating one’s sensory experiences to one another, one takes recourse to similes (Scarry 1985:15, quotes V.C. Medvei). Rather than describing the experience itself, one invokes a certain situation and says it feels ‘as if’ this and that were happening. The assumption is that people in similar situations have similar sensory experiences. However, considering the complexity of pain experiences, this assumption is actually rather ill founded.

After repeated experiences of being needled, I learnt to distinguish between *tong* and *suan*, *ma*, *zhang*, although in my experience the boundaries between these feelings could be very fluid. Instances of *tong* clearly were unpleasant, it hurt ‘as if’ skin tissue were damaged, while instances of *suan*, *ma*, and *zhang*, even if initially experienced as an unpleasant pricking, could also be experienced as a welcome sort of stimulation once one was accustomed to this sort of ‘pain’. Accordingly, rather than speaking of pain, Sagli (2003:215) calls *de qi* an ‘unfamiliar body sensation’.

However, to call *de qi* a ‘sensation’ is problematic, for *tong* and *suan*, *ma*, *zhang* are complex forms of ‘perception’ rather than ‘sensations’. These sensory experiences are not reflex reactions but both physiologically and culturally modulated ‘perceptions’. When I described *tong*-pain above with a simile I made the assumption that ‘skin tissue damage’ was a very distinctive feeling among all humans, but ‘skin tissue damage’ is actually an experience that presupposes concepts like ‘skin tissue’ and is accordingly a socially and culturally shaped perception. To be sure, the terms *tong* and *suan*, *ma*, *zhang* refer to specific forms of ‘perception’.

That one’s experience of pain is a ‘perception’ rather than a ‘reflex’ or ‘sensation’ has been convincingly demonstrated through sociological studies of pain, which centred on its culturally specific expression.<sup>3</sup> A classic is Mark Zborowski’s (1952) on ‘Cultural Components in Responses to Pain’ caused by herniated discs and spinal lesions. It was a carefully thought through study that involved open-ended interviews with 103 respondents, and also accounted for intra-group variation. However, as has been rightly remarked (Kleinman et al. 1992:2): ‘We blush to read these descriptions today’. The study not only elaborates cultural stereotypes from the study of male veterans, but also states unashamedly that (I quote Kleinman et al. 1992:2): ‘Yankees are continent; Jews and Italians are expressive; Jews are more concerned with the future significance of their pain; Italians, focused on the present, are simply relieved that the pain has gone away.’ Zborowski’s study and many that followed, which centred on the cultural factors in the response to pain, were important despite their reinforcement of cultural stereotypes, because they led to the general acceptance that pain is not a

‘reflex’ or ‘sensation’ but a complex ‘perception’ with a more or less strong emotional component. It is shaped by culture, gender, age, status, et cetera, apart from personal disposition.

The differences of pain intensity and quality, of its modulation through simultaneous cognitive processes and emotional experiences, of cultural meanings, age and gender, social status and personal disposition, cannot be overlooked. These differences may be so important that the use of the one word ‘pain’ may not do justice to the diversity of the lived experiences. The radical solution would be to do away with the concept of ‘pain’ altogether, because it essentialises the diversity of painful sensory experiences in social life. However, for the purposes of making sense of the therapeutic quality of *de qi* in Chinese acupuncture, one need not be as radical as this, and in what follows, I propose to differentiate merely between an anthropologically defined ‘acute’ versus ‘chronic’ pain.

### **Culturally constructed temporalities of acute and chronic pain**

Considering the diversity of pain experiences, it comes as no surprise that the anthropological literature does not address pain as such but rather, social practices and medical problems marked by specific pain experiences: initiation rites; torture and war trauma;<sup>4</sup> and chronic pain in medicalised societies. This is not to say that other themes have not been discussed, such as masculinity gained through painful gym experiences (Frykman 1998) or pain experiences among intravenous needle sharers (Connors 1994), and others.

Anthropologists generally consider pain infliction in initiation rites ‘meaningful pain’. Clastres (1973), as already mentioned, highlights its disciplinary function of inscribing the laws of society on individual male bodies. In her discussion of a female initiation rite, pharaonic circumcision, Janice Boddy stresses a remarkably similar aspect of acute pain infliction:

Through this operation and other procedures involving pain or trauma, appropriate feminine dispositions are being inculcated in young girls, dispositions, which following Bourdieu (1977:15), are inscribed in their bodies not only physically, but also cognitively and emotionally, in the form of mental inclinations, ‘schemes of perception and thought’ (1989:57).

Boddy and Clastres both emphasize how in these initiation rites the cognitive and emotional is physically inscribed in bodies; both would shy away from the notion of ‘physical pain’. Boddy then goes a step further by contextualising the culture-specific form of acute pain infliction in a field of symbolic attributions. She explains how in Hofriyat heat and pain, known by the same word, *harr*, come to be understood as intrinsically feminine qualities; it is both the women’s internally felt pain and heat, and their association with the fluids water and blood, that makes them fertile and feminine. Women should be pure, their skin smooth, white, and without hairs, and by closing off their genital opening, they should preserve moisture. It is the enclosed moist female body, characterised by *harr*, that has generative and transformative powers.

Having said this, culture-specific meanings associated with the practices of female circumcision are ambivalent and ambiguous. They change and can even become meaningless to some (Gruenbaum 1996), particularly in transnational contexts (Johansen 2002). Therefore, rather than calling the ritually inflicted pain 'meaningful pain', I suggest assessing it in light of its culturally given temporality. The temporality that marks initiation rites is typically structured and ever since Van Gennep (1909) considered to have three phases. Acute pain is usually contained within the liminal phase. I suggest calling it 'acute pain' because it occurs in a given temporal structure with a clearly demarcated beginning and end.

The definition of 'acute pain' as pain experienced in culturally demarcated temporalities that delineate the beginning and end of the experience differs from the biomedical definitions of acute and chronic pain. For the biomedical profession, as Kleinman et al. (1992) put it, somewhat polemically, acute pain is real, but chronic pain not. The reality of acute pain can usually be related to tissue damage, albeit to varying degrees. It typically has sympathico-adrenal manifestations:

Gastrointestinal responses are characterised by an inhibition of motility ... Glucogen is released from the liver into the bloodstream as an energy source. Respiratory changes characterised by increased alveolar ventilation and oxygen consumption, and occasionally increased respiration rate may be associated with the hyperventilation. Muscular responses include both gross hypermotility and increased muscle tension in the area of painful stimulation... Cardiovascular responses are more complex and varied, but usually there is a marked elevation of both systolic and diastolic pressures... there is also an increase in pulse rate... Pupillary dilations, palmar and plantar sweating and escape behaviour and vocalisations are also easily-observable responses (Sternbach 1984:174).

Since these physiological aspects of the pain experience are always modulated by emotion and cognition, biomedical doctors too shy away from the concept of 'physical pain' (Craig 1984, Weisenberg 1984).

Biomedical doctors are well aware that 'chronic pain' is a completely arbitrary convention; sub-acute or ongoing acute pain gets reclassified as chronic pain after six months (Sternbach 1984). Not only is there no function for chronic pain, it often cannot be directly correlated with tissue damage and, while chronic pain does change and transform the person and his or her physiology, the physiological features generally are not those that mark an acute pain episode.

In accordance with the biomedical definitions of acute and chronic pain, one could say that initiation rites inflict acute pain experiences; the duration may be of seconds, minutes, hours, days, and weeks, but hardly of months and years. However, rather than referring to absolute time entities (of more or less six months), it seems more useful to coin these terms in the light of culturally defined temporalities. Accordingly, 'acute pain' is experienced in culturally clearly demarcated temporal structures and 'chronic pain' is defined by a culturally unstructured temporality.

Morris (1990) emphasizes that chronic pain is peculiarly unregulated and Kleinman (1988) illustrates with moving personal histories how it leads to withdrawal and isolation. Chronic pain is unreal for the other, while it is so terribly present and

all-encompassing for the sufferer, and this impossibility of the other to empathise with the sufferer enlarges the latter's pain experience. Time becomes distorted, the subjectively suffered pain cannot be socially validated, inner and outer time seem out of sync, the sufferer lives in a temporality isolated from social time (Good 1992). Chronic pain debilitates and alienates, it has a peculiarly changeable nature, and while it is distressing in its milder appearances, it is excruciating at its worst (DeVecchio Good 1992). The sufferer then experiences, as one does in acute pain, that mind-body and subject-object dualisms break down, because pain is simultaneously bodily experience and mental-emotional experience, which resists objectification (Jackson 1994). These accounts all report on temporally unstructured and peculiarly changeable pain experiences. They are best comprehended in terms of the above coined anthropological concept of 'chronic pain' that by definition is marked by a culturally unstructured temporality.

### **Temporally structured acute pain in ritual and unregulated chronic pain in medicalised societies**

Chronic pain belongs among the most frequent reasons for disablement in the United States and the European Union (Kleinman et al. 1992).<sup>5</sup> No doubt, 'chronic pain', like 'PTSD' (Young 1995), is one of these cultural constructs of societies in the northern hemisphere that due to globalisation processes are reified also in other cultural settings. However, regardless of whether they are cultural constructs or not, and whether they are indefinable due to their diversity or not, the lived experience of the peculiarly changeable sort of pain known as 'chronic pain' is real. Medical anthropologists have amply documented this.

Ivan Illich (1976) describes the 'killing of pain' as one of the prime features of what he dubs 'medicalised society'. He traces the marketing of the first medicine called 'pain killer' to 1853 – to be succeeded by aspirin in 1899, which, despite the more recent popularity of valium and cocaine, remains the main painkiller to date (Morris 1990). According to Illich:

Progress in civilization became synonymous with the reduction of the sum total of suffering. From then on, politics was taken to be an activity not so much for maximizing happiness as for minimizing suffering. ... In this context it now seems rational to flee pain rather than to face it, even at the cost of giving up intense aliveness. It seems reasonable to eliminate pain, even at the cost of losing independence. ... With rising levels of induced insensitivity to pain, the capacity to experience the simple joys and pleasures of life has equally declined. Increasingly stronger stimuli are needed to provide people in an anaesthetic society with any sense of being alive. Drugs, violence and horror remain the only stimuli that can still elicit an experience of self (1976:106).

Medicalised society is marked by the intention to minimise pain at the cost of recognising, as Illich says, 'in the capacity for suffering a possible symptom of health' (ibid.). Incidentally, life cycle rituals have also been drastically reduced in scale and

frequency in medicalised societies. For instance, the social management of pain in birthing is minimised by anaesthetics or caesareans, and the mere thought of painful initiation rites is abhorrent. The corpses of the dead are deported to hospital and hung on to dehumanising revitalisation machines instead of being mourned over at the bedside in an intensely felt, temporally structured acute pain episode. Likewise, lavish wedding ceremonies are on the decline, where the pain of separation from the one family and the anxiety accompanying entry into the other, is eased by being together in an exalted social gathering.

In medicalised societies acute pain is not openly displayed. Great efforts are made to suppress it whenever it surfaces – with the compartmentalisation of suffering into institutions that make death and protracted illness invisible to daily life and with pain killers that reinforce the imperative of individual autonomy. However, pain manifests itself in the silently increasing chronic pain syndromes. Interestingly, this overt versus covert expression of pain parallels that of the power of government. As power is no longer displayed in a spectacle of inflicting gruesome pain in punishment, but has become invisible (Foucault 1975), acute pain episodes are rarely played out in temporally structured life cycle events. Yet people increasingly suffer from peculiarly unregulated temporally unstructured chronic pain syndromes. Chronic pain syndromes, which result in the complete isolation of the individual, are bound to reinforce the currently observed fragmentation of medicalised societies. By contrast, acute pain events in life cycle rituals make possible the embodied experience of social cohesion, which indirectly may strengthen the health of all participants, as may the above described therapeutic measure of *de qi* in Chinese acupuncture.

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## Notes

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*Qi* is the 'stuff that makes things happen' or 'the stuff in which things happen'. It is rendered in translation as 'breath', 'air', 'vapour', or 'energy' (Sivin 1987:47).

2 See also authors cited in Illich (1976: chapter 6), Scarry (1985), Morris (1990), Rey (1995).

3 And more recently also on gender-specific ones (for example Bendelow 2000).

4 The experiences of torture and trauma, which Scarry (1985) conceptualises as 'physical pain', and their effect on the unmaking and making of culture, are too complex an issue to be discussed in this essay.

5 See for example [http://www.efic.org/ewap\\_part2.htm](http://www.efic.org/ewap_part2.htm), accessed September 2005.

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