

An Embodied Approach to Gender in the Construction of Pain in Everyday Life

by

Karen M. Steinmayer

-

A dissertation submitted to the Graduate Faculty in Psychology
in partial fulfillment of the requirements for the degree of
Doctor of Philosophy, The City University of New York

2006

UMI Number: 3204986

Copyright 2006 by
Steinmayer, Karen M.

All rights reserved.



UMI Microform 3204986

Copyright 2006 by ProQuest Information and Learning Company.
All rights reserved. This microform edition is protected against
unauthorized copying under Title 17, United States Code.

ProQuest Information and Learning Company
300 North Zeeb Road
P.O. Box 1346
Ann Arbor, MI 48106-1346

©2006

KAREN M. STEINMAYER

All Rights Reserved

This manuscript has been read and accepted for the
Graduate Faculty in Psychology in satisfaction of the
dissertation requirements for the degree of Doctor of Philosophy

December 13, 2005
Date

Leanne G Rivlin
Chair of Examining Committee

December 13, 2005
Date

J. Glick
Executive Officer

David L. Chapin

Suzanne C. Ouellette

Shirley Lindenbaum

John P. Kuhl
Supervisory Committee

THE CITY UNIVERSITY OF NEW YORK

Abstract

AN EMBODIED APPROACH TO GENDER IN THE CONSTRUCTION OF PAIN
IN EVERYDAY LIFE

by

Karen M. Steinmayer

Advisor: Professor Leanne G. Rivlin

This study's goals are to investigate the roles of psychological, social and cultural factors in women's and men's constructions of pain and to contribute to a biopsychosocio-cultural model of health and illness. The research draws on narrative theory, life story construction and structuration to explore how gender and human pain are intersubjectively constructed through practices and discourses which occur in real places during everyday life. Four methods, 1) writing two narratives; 2) drawing two maps depicting experiences of pain when participants were seven through eleven and twelve through seventeen; the Life Story Interview, and the standardized Coping Styles Questionnaire, address three research questions: **1) How are women's and men's constructions of pain similar and different? 2) In what types of places do women and men have experiences of pain? 3) What do women and men do to deal with pain?** Eleven women and eight men, ages twenty-four through forty-eight, participated. 1) Participants displayed awareness of the Western biomedical separation between physical and emotional pain. 2) Participants weren't able to maintain this distinction 3) Participants connected pain to many aspects of their

lives; 4) The ways families dealt with pain was related to the ways participants reported dealing with pain as adults. 5) The second drawing was an important point in the interview. Participants constructions appeared to change at about age eleven. Physical and emotional pain became connected and tied to identity, gender, ethnicity and class. Gender emerged as an important factor: 1) Women reported talking to others is important to them while men reported not liking to talk about pain. 2) Men, but not women, talked about a syndrome which linked pain sensations to emotions, sense of self and the importance of physical activity. 3) Women were comfortable talking about relations between physical and emotional pain, while men were not. 4) Female participants were more likely to portray themselves in or close to their homes, including in bedrooms and in bed, while male participants were more likely to depict themselves in outdoor environments farther from their homes. The construct of hegemony and gender identity theory are employed to explain these results.

Acknowledgements

I would like to begin by thanking the five members of my committee, who have all been consistently kind, supportive, generous and enthusiastic about this project. Each has been able to draw on special areas of expertise to provide a unique perspective on the project as it developed, making it infinitely richer and more comprehensive. I would especially like to thank my advisor and the chair of the committee, Dr. Leanne Rivlin. It is difficult to know what to say to thank such a remarkable person. She is a wonderful person and a gifted and inspiring scholar and teacher. She has shown me unbelievable kindness and generosity. She has displayed unwavering interest in this project as it developed and in me as I grew and progressed.

I would like to thank the nineteen research participants. They were all open and willing to become actively engaged in an interview which must, at times, have seemed somewhat unusual. Moreover, the interview was long. But, these nineteen participants gave unstintingly of their effort and time. I am very grateful to them.

I would like to thank Larry, Dr. Lawrence Henry Snow, without whom I don't think I would be alive today. I wish he had lived to see this work completed.

I would like to thank my friends and family, the people who have helped me become who I am today. My friends have "been there" for me at times and in ways that tug at my heart as I write this. I can only thank them for their loyalty, support and friendship. Of course, a special "thank you" goes to my family, who have "been there" from the start. I especially thank my parents for their love,

help and guidance. It was during those lively dinnertime debates that, I think, my academic work was launched.

Thank you-all! There is nothing I can say to thank you enough!

TABLE OF CONTENTS

Chapter One: The Theoretical Background for This Study.....	1
Chapter Two: Methodology	62
Chapter Three: The Research Participants	87
Introduction to Chapters Four, Five and Six.....	104
Chapter Four: Overall Patterns of Pain in Everyday Life	105
Chapter Five: How Does Pain Figure in a Life?: Five Life Sketches.....	187
Chapter Six: The Narratives, the Maps and the Scale	296
Chapter Seven: Discussion	341
Chapter Eight: Implications and Suggestions for Further Research	423
Appendices	447
References	479

LIST OF TABLES

Table 1: Demographic Characteristics of Women in the Study.....	100
Table 2: Demographic Characteristics of Men in the Study	102
Table 3: Topics of Participants Two Narratives and Two Drawings	183
Table 4: Coping Styles Questionnaire	337
Table 5: Participants' CSQ Scores Compared to Ways of Dealing with Pain which They Described Spontaneously	339

Chapter One

THE THEORETICAL BACKGROUND FOR THIS STUDY

“When my body thinks...all my flesh has a soul.” (Colette, 1907)

“The intending body has a story. A story devoid of meaning for those living it creates a body which is an ‘object body’.” (Cole & Paillard, 1995)

INTRODUCTION TO THE CHAPTER

A major objective of this chapter will be to explain why gender differences in the perception of and tolerance for pain present an especially suitable topic for research on both the human experience of pain and on an environmentally oriented, biopsychosocio-cultural model of human health and illness. This chapter will also present and explain the theoretical material on which the design and methods used in this research are based. The chapter begins with an explanation of the problems which will be addressed in this research. Next, major issues in the study of pain are delineated to illustrate the complexity of the phenomenon of human pain and explain the limitations presented by strictly physiologically based theories of pain. This is followed by the presentation of an alternative, more culturally and psychosocially oriented view of human bodily experience. This presentation includes a detailed explanation of why an embodied, phenomenological perspective provides the most promising framework for the current research on gender differences in the construction of pain. Finally, the situated, place-based nature of the construction of human bodily experience is discussed, highlighting the important role of place in this study.

THE GENESIS OF MY INTEREST IN INVESTIGATING A BIOPSYCHOSOCIO- CULTURAL MODEL

I became interested in investigating a model of human health and illness which takes into account the psychological, social and cultural dimensions of human bodily experience through working on research, especially in clinical settings, where models which adhered to a rigid bifurcation between body and mind, such as the biomedical model, did not seem to offer explanations which could help people. Work with people with chronic illnesses and substance abuse problems, in particular, led me to become interested in investigating a model of human health and illness which could take psychological, social and cultural factors into account.

An especially striking experience occurred during a group therapy session being conducted for in-patients with substance abuse problems at Bellevue Hospital/NYU Medical Center. On this particular day, I remember that all the patients participating in the session were seated in a circle. The social worker began the session by asking the clients to go around the circle and take turns explaining how they felt when they needed to take a drink. When his turn came, one bright and well-spoken client just didn't seem able to come up with the words he needed to express how he felt. He kept saying that, when he felt that he needed to take a drink, that described exactly how he felt, like he needed to take a drink. This client was an especially intelligent fellow, who seemed to be quite well educated and had an extensive vocabulary. In addition, within the context of the group, based on what other clients were saying, what he was expected to say was clear. All the other clients had said something about feeling angry. Obviously, this was the expected

response. But, this man did not provide it. Instead, he kept insisting that, when he felt like he needed to take a drink, that was how he felt, like he needed to take a drink. No other words could describe it. Finally, we moved on to the next member of the group.

This experience made a profound impression on me. The client knew what he was expected to say. Moreover, the situation in this group had become uncomfortable for him because he was not saying what was expected. He was being asked to explore his own emotions. This appeared to be what he found and, most importantly, it seemed to matter to him very much that he continue to assert that this was his experience, that there were no other words which could express how he felt when he needed to take a drink. Since I couldn't put this session out of my mind, I recounted this experience to my advisor. This extremely elegant and distinguished gentleman proceeded to amaze me by leaping out of his seat while crying out loudly, "Alexithymia! That's alexithymia!". After calming down somewhat, he explained that the construct of alexithymia meant "not having words for emotions" and was attracting a good deal attention in some circles.

I later learned that the construct of alexithymia (Sifneos, 1973) had been connected with a delimited group of disorders which seem to transcend the bifurcation between mind and body usually made in Western biomedicine. Usually included in this group of disorders, often referred to as the "classic psychosomatic disorders", are some forms of arthritis, diabetes, some forms of headache, bronchial asthma, essential hypertension, some forms of cardiovascular disease, gastric ulcer, peptic ulcer, and ulcerative colitis (Alexander, 1950; Taylor, Bagby & Parker, 1991).

In the late 1940's and early 1950's, clinicians had begun to observe that their interactions with patients who exhibited these “classical” psychosomatic disorders seemed to share certain features (Marty & de M'uzan, 1963; McDougall, 1980; Nehemiah & Sifneos, 1973). For example, McLean (1949) noted that his psychosomatic patients seemed to have difficulty verbalizing feelings. He suggested that this group of patients might be discharging emotion through autonomic pathways in what he termed “organ language” rather than processing affect in the neo-cortex, or “word brain”, the area of the brain more usually devoted to processing language. I began to wonder why people would not have words for their emotions and, especially, why not having words for one's emotions would have anything to do with drug use. However, I searched for a long time before I identified a research problem which I thought would open a way to address a model of human and health and illness which did not bifurcate mind from body and could take psychological, social and cultural factors into account.

THE PROBLEM ADDRESSED IN THIS STUDY

Gender differences in the perception of and tolerance for pain as a uniquely appropriate “portal” for investigating a psychosociocultural model of human health and illness

The topic of gender differences in the perception of and tolerance for pain presented a uniquely appropriate entry point for the investigation of such a model. Relatively consistent differences between women and men in the perception of and tolerance for pain have been observed in experimental studies (Gijsbers & Niven,

1995; Riley, Robinson, Wise, Myers & Fillingim, 1998; Fillingim, Edwards, & Powell, 1999). However, although experimental researchers have attempted to explain these differences in solely physiological terms, efforts to account for human pain using the strictly physiological approach of the biomedical model have not been successful. Pain seems to be a phenomenon which challenges the epistemological orientation and key assumptions of the biomedical model, that human health and illness are based solely on objective, physiological occurrences which can be known apart from subjective experience. The human experience of pain appears to be complex. Psychological, social and cultural factors seem to play significant roles in human pain (Lackner, Carosella & Feuerstein, 1996; Robinson, Riley, & Myers, 2000).

Both because such consistent gender differences have emerged in experimental studies and because psychological, social and cultural forces, such as those involved in gender socialization and acculturation, appear to play important roles in the human experience of pain, a psychosocio-cultural investigation of gender differences in the construction of pain appeared to offer a uniquely appropriate entrance point for investigating two related issues. The study's first goal is to investigate the part psychological, social and cultural factors play in the ways women and men construct their experiences of pain. The second, related, aim of the study is to contribute to the understanding and development of a biopsychosocio-cultural model of human health and illness.

There are fundamental differences between the biomedical model and the environmentally oriented biopsychosocio-cultural model, which also suggest

differences in care and treatment (S. Taylor, 1995). The biomedical model focuses on illness, devoting little attention to health. In the biomedical model, human illness is bifurcated from human health. As a result, health is defined as the absence of disease and illness is defined solely in terms of the absence of health. In the biomedical model, there is also a dualistic separation of mind and body. Thus, illness, viewed as the absence of health, is considered solely in terms of an objectively identifiable, single, physiological factor, the disease- causing pathogen which produces illness in the human body. Moreover, human mental processes receive little attention in the biomedical model. Pain has often had a problematic, uncertain status in biomedicine, with pain patients, especially those whose pain cannot be readily or successfully treated, frequently regarded as “problem” patients (Good, Brodwin, Good and Kleinman, 1992).

In contrast to the biomedical model, the biopsychosocio-cultural model takes a broader view of human health. This model takes both health and illness into account, resulting in a perspective on health that encompasses more than just the absence of disease (S. Taylor, 1995). The biopsychosocio-cultural model also rejects the mind-body duality of the biomedical model. In a biopsychosocio-cultural model, micro-level processes such as the biological, physiological and psychological are integrated with macro-level social and cultural forces, providing a standpoint in which the continuum of human health and illness is viewed in terms of multiple factors, involving mind, body, society and culture. In 1981, in an effort to counter the reductionistic, biological orientation of the biomedical model (Lock, 1999), the World Health Organization (WHO) defined health as a state of physical, mental, social and

spiritual well-being. The biopsychosocio-cultural model offers a perspective from which to view human health and illness in accordance with such a definition.

This research is grounded in an environmentally-oriented, embodied, phenomenological perspective. From this perspective human bodily experience is considered to be, at least in part, intersubjectively constructed between people, in contrast to the physiologically-based view provided by the biomedical model. Moreover, the interpersonal exchanges through which this intersubjective construction takes place are viewed as being fundamental to the creation of meaning. Meaning is considered to play a key role in human physiological functioning, exerting a profound effect on health and illness in humans. Because these interpersonal exchanges take the form of social discourses and practices which occur in explicit places in the physical environment during the course of everyday life, this study will examine experiences of pain which have taken place in the course of the research participants' everyday lives. Participants who report experiencing chronic or clinically significant pain will not be recruited for this study. Participants will be asked to situate their everyday experiences of pain using a map drawing method.

THE COMPLEXITY OF PAIN

Human pain appears to be a profoundly complex matter. This description of research on pain is presented to illustrate this complexity. Due to its complexity, while pain has been studied from a variety of perspectives, it has not been adequately explained. Moreover, it is difficult to investigate human pain, which is a

deeply personal, phenomenological experience. As such, as Elaine Scarry (1985) in particular, has elucidated, pain in another person cannot be directly observed or objectively measured. Another person's experience of pain can only be evaluated based on the descriptions and behaviors presented by the sufferer (Clark, 2001; Scarry, 1985). Although, in the past, scientists with a more biologically and physiologically based perspective dreamed of developing a "pain thermometer", there is now general agreement that such an objective measure of pain is not feasible. As Good et al. (1992, p. 6) explain, "There is no objective measure of pain, no 'pain thermometer' because the experience of pain is inseparable from personal perception and social influence."

Psychosocial and cultural explanations for gender differences found in experimental studies of pain

In the experimental studies of pain in which fairly consistent gender differences have been noted, precisely calibrated, noxious stimuli are applied, often in a sequence of graded intensities. Research participants are asked to make judgements concerning the presence, absence and intensity of the stimulus. For ethical reasons, experimentally induced pain must be short term and its effects must be reversible (Clark, 2001). The cold pressor test (CPT) is one such experimental procedure. In laboratory procedures employing the CPT, research subjects are asked to submerge their hands in water so extremely cold that it is painful. Ratings of pain in the CPT are based on the research participant's subjective verbal report of the degree of pain while tolerance for pain is measured by the length of time the

research participant keeps his or her hand in the water. Based on these criteria, males generally report lower average subjective ratings of pain severity and show higher tolerance for pain on the CPT (Riley et al., 1998). However, it is not clear to what extent such gender differences might be due to differences in physiological make-up, such as neurosensory sensitivity, and to what extent such differences might be due to psychological, social and cultural factors.

At the physiological level, gender differences in the perception of and tolerance for pain have been hypothesized to be due to a more sensitive secondary pain (C-fiber) system in women (Clark, 2001). The presence of some physiologically based differences between men and women in pain perception and tolerance appears to be supported by research conducted by Goolkasian (1980). Goolkasian demonstrated that, while women seem to have heightened sensitivity to pain during ovulation, when ovulation is inhibited through the use of oral contraceptives the observed change in pain sensitivity across the menstrual cycle no longer occurs. Female subjects' perception of pain when ovulation is inhibited becomes comparable to that of male subjects. Thus, Goolkasian's work suggests that female hormones may contribute to heightened sensitivity to pain.

Differences in the socialization and acculturation of females and males may contribute to a response bias on the part of women to report more pain and to more quickly and easily display signs of discomfort and inability to withstand pain, while, conversely inclining men to avoid complaining and endure pain. Bandura (1997) suggested that both parents and peer group members may expect males to be physically strong. He also pointed out that media representations of males portray

them as physically strong and athletic, possessing greater endurance than females. In his qualitative study of the association between pain perception and gender, Bendelow (1993) found that people reported learning how to respond to pain when they were very young. Male participants recalled that during childhood they were actively discouraged from expressing emotion and encouraged to be stoic when experiencing pain. On the other hand, Sullivan, Tripp and Santoe (2000) have suggested that women are socialized to communicate about pain and to engage in interpersonal and communal strategies for dealing with pain.

While in our culture it is generally acceptable for women to cry and express discomfort when they experience pain, such behavior is usually far less acceptable for men. As a result, women may be less concerned that they will violate social expectations if they express discomfort and are unable to keep their hands in painfully cold water while being observed. However, male research participants may feel that it is necessary for them to avoid complaining and keep their hands in the freezing cold water for as long as possible in order to display gender appropriate strength and endurance. Thus, it seems that the gender differences in pain perception and tolerance observed in experimental studies may be influenced by psychological, social and cultural messages conveyed in the course of daily life activities conducted in the physical environment.

Other limitations of strictly physiological explanations of pain.

Strictly physiological explanations have failed to explain such aspects of the human experience of pain as why subjective psychological factors like suggestibility,

attitude, expectation, anxiety, motivation, and attention or distraction appear to affect pain perception (Melzack, 1970,1973: Melzack & Wall, 1983). A person's goals, purposes and activity level seem to modulate the human experience of pain. For example, a frequently observed phenomenon is that a person injured in battle, or in the throes of a hotly contested competitive sport, may not seem to experience the same degree of pain as a person who is unoccupied at the time a very similar injury is incurred. In the midst of activity and excitement, physiological and cognitive responses to the pain appear to act in concert to limit the perception of pain. In addition, in such situations, sensory signals that might be perceived as painful under other circumstances appear to signify the achievement of valued goals, affecting the perception of and tolerance for pain (Clark, 2001). While physiological evidence has been found which demonstrates that under conditions of shock and stress the body manufactures opiate-like peptides, it has also been well established that the mind and emotions can powerfully increase or diminish people's perceptions of pain (Morris, 1991).

In 1946, Beecher published what is considered to be a classic study of men wounded in battle in which he focused on men wounded on the Venafrro and Cassino fronts and, later, Anzio, during World War II (Morris, 1991). Beecher was surprised to find that when seriously injured soldiers were questioned within twelve hours of being wounded, 25% reported experiencing only slight pain while 32% reported that they did not experience any pain at all (Beecher, 1946: Morris, 1991). Moreover, 75% of these men experienced so little pain after being wounded that they refused medication. These findings were all the more surprising because the

same men who reported so little pain from their war wounds did not display an overall decrease in sensitivity to pain. For example, many protested about the pain caused by such relatively mildly painful experiences as an ineptly performed venous puncture. Beecher's explanation was that the emotions associated with being wounded made the difference. He thought that if the same men experienced similar injuries as civilians, such as being injured in an automobile collision, they would show only normal tolerance for the pain. Beecher conjectured that their wounds carried positive meanings, especially offering release from the extremely dangerous environment of the battlefield. Conversely, the meaning of similar injuries for a civilian in an automobile accident would be very different, possibly signifying a need for costly, painful and even life-altering treatment along with a diminished capacity for making a living. Morris (1991) makes the important point that these examples demonstrate that pain is not a timeless, universal phenomenon but, rather, takes place at specific times and places, the circumstances of which affect the meaning and the nature of the experience of pain.

The phenomenon of "audio analgesia", stimulation of the auditory system which affects the threshold for pain, offers another challenge to a strictly physiological theory of pain. Audio analgesia has frequently been used to relieve pain experienced by dental patients undergoing drilling and tooth extraction. These patients are provided with headphones through which they can hear both stereophonic music and a hissing sound. They are instructed to increase the noise level of the stereophonic music and the hissing noise, respectively, from when pain is first felt until relief occurs. This form of sound stimulation has served as the

single, effective analgesic during several thousand dental operations (Gardner, Licklider, & Weisz, 1960). It is not clear whether audio analgesia is effective because it distracts the patient from the pain, because the procedure carries the suggestion that the pain will be lessened, or whether the lessened perception of pain is due to the patient's perception that he or she is able to exercise some control over the situation, leading to a reduction in anxiety. However, it is also possible that this procedure is effective because of an unidentified pain inhibitory physiological mechanism.

Ethnicity, culture and pain.

Zborowski's (1969, 1952) studies of the role of ethnicity in pain expression, conducted first in a veteran's hospital in New York state and, later, at Mt. Zion Hospital and Medical Center in San Francisco, offer a classic illustration of ethnic differences in pain experience. As a result of his study of veterans in upstate New York (Zborowski, 1952), he reported that Irish and New England Yankee participants were stoic in the face of pain while Jews and Italians were more likely to express discomfort and distress. While Jewish participants tended to be concerned with what the pain they were experiencing signified for the future, Italian participants were more likely to stay focused on the present situation, simply expressing relief when the pain dissipated.

In his later study of male war veterans at Mt. Zion Hospital, conducted between 1951 and 1954, Zborowski (1969) reported that, although one might expect that all these male veterans would share common values as a result of their war

experiences, this was not wholly the case. Zborowski found that pain was not only an individual experience, but that the men's responses to pain were strongly and systematically influenced by their ethnic and class backgrounds. He found that the men he interviewed fell into four major groups, which he classified by ethnicity as Irish, Jewish, Italian and Old American (Yankee). The last group, which he designated Old American, was comprised of men whose families were White, Anglo-Saxon and, usually, Protestant. Zborowski found that the Jewish and Italian men he interviewed tended to be uninhibited and expressive about their pain while the Irish and Old American men tended to keep silent, deny or hide their pain and to try to avoid the company of others.

While behavior among the men within these four ethnic groupings tended to be strikingly similar, there also were similarities among the men which cut across these ethnic boundaries and seemed to be related to social class. Men from lower socioeconomic backgrounds tended to interpret their pain as threatening their financial well-being due to potential unemployment or diminished ability to work. Irish and Old American men, faced with this situation, attempted to interpret their pain in ways which would serve to minimize such dangers. For example, they gave "safe" explanations for their pain, such as interpreting their pain as something minor like a cramp or sore muscle.

Pain appears to be experienced differently by people from different cultures. Ots (1991, 1990) reports that among the Chinese it is quite common for people to experience headaches characterized by dizziness or vertigo. This form of complaint seems to be the embodiment of a traditional Chinese medical category of imbalance.

Abad and Boyce (1979, p.34) report that North American Latinos distinguish between "headache" and "brainache", as two different disorders which involve different experiences of pain, while Ebigbo (1982, p. 2) discusses the wide range of specific pains which constitute common complaints among Nigerians. These include "it seems as if pepper were put into my head", and "things like ants keep on creeping in various parts of my brain".

Payer (1988) found that cultures are strikingly different in the body organs on which they focus as presumed sources of pain. He noted that Germans are more likely to complain about heart pain while the French are more likely to focus on the liver and the English on the gastro-intestinal tract. Clark and Bennet Clark (1980), using a Signal Detection Theory (SDT) method, found that the ability of Nepalese Sherpas to discriminate among noxious electrical stimuli was very similar to that of people from Western European cultures. However, they also found that the Sherpas reported pain only at much higher levels of stimulation than the Western European research participants, suggesting that they had a more stoic criterion for the report of pain. Clark and Bennet Clark attributed this difference in pain report to differences in culture, suggesting that this cultural difference might be related to the harsh climate in which the Nepalese Sherpas live.

These individual, ethnic and cultural differences in the experience of pain make it difficult to formulate overall statements about the psychophysics of pain. Among these differences is the evidence of gender differences in pain sensitivity and thresholds, which will be the focus of this study. An adequate theory of pain must be able to account for how factors such as memories of past experiences of pain,

meaning associated with the experience of pain, current attitudes and expectations regarding pain, gender, ethnicity and culture affect the ways in which different individuals experience painful stimuli.

Theories of pain

It is unclear whether pain represents a distinct perceptual modality and, beyond this, whether pain can even be limited to the realm of perception. As we saw in Beecher's (1946) studies of men wounded in war, meaning and emotion appear to affect the experience of pain. In our culture, people sometimes talk about both the physical pain resulting from stubbing a toe and the emotional pain attendant on a serious disagreement with a close friend using the same term, "pain". There also are many different classes of pain among which people distinguish. For example, "sharp" pain is usually described as being clearly localized and eliciting an immediate reaction, while "dull" pain often seems to originate deep within the body, be poorly localized, and cause other bodily reactions, such as sweating and palpitations (Bekesy, 1971).

Theories of pain have varied widely through the course of Western European history, going as far back as Aristotle. A central issue of debate among pivotal thinkers for thousands of years has been whether pain can be viewed as a strictly physiological phenomenon or whether emotion and affect are an intrinsic part of the experience of pain. Aristotle thought of pain primarily in terms of emotion and did not consider pain to be a sensation at all (Morris, 1991). During the nineteenth century, physiologists went to the other extreme, arguing that pain is entirely sensory

and completely devoid of emotional input. Sherrington, the distinguished physiologist, combined these two views, hypothesizing that there were two dimensions to pain, the sensory and the emotional or affective (Morris, 1991). More recently, Melzack and Casey (1968) have speculated that pain might have three dimensions, including a third dimension of cognition and evaluation along with the sensory discriminative dimension and the affective-motivational dimension. Loeser (1980) and Fordyce (1988) both described pain in terms of four dimensions. First, they hypothesized that nociception, the activation of the fibers that usually respond to noxious stimulation, took place. Next came the actual experience of pain, the sensation that usually follows nociceptive stimulation. They also posited a third dimension which they termed “suffering”, in which they included the affective and emotional responses of the Central Nervous System such as anxiety, depression and fear. Finally, they suggested the presence of a fourth dimension of pain behaviors, in which they included the observable muscular and autonomic activities of people experiencing pain.

Thus, theories of pain have ranged from theories in which pain is considered only in terms of sensory input to theories which allow for the contribution of emotion and motivation, evaluation and even behavior. Overall, theories of pain have been divided into three general types: specificity theories, pattern theories and theories which combine aspects of specificity and pattern theories, such as the gate control theory of pain (Melzack, 1973; Melzack and Wall, 1965).

According to specificity theories of pain, pain is a separate sensory modality with its own distinct set of peripheral pain receptors. According to pattern theories,

general stimulus intensity or the summation of neural impulses by a central mechanism is critical in determining the experience of pain. According to the spinal gate control theory of pain, in part a specificity theory and in part a pattern theory, a competitive interaction occurs between two different kinds of nerve fibers which reach the first transmission cells of the spinal cord. Proponents of this theory posit that a neurological gate control system exists within the spinal cord that “gates”, or modulates, the amount of nerve impulse transmission from peripheral fibers of the skin to T cells. Pain occurs when the output of the T cells reaches or exceeds a critical level. The total number of active fibers and the relative balance of activity in large and small fibers at the point of the spinal gate determines the excitatory effect on the T cells. When the impulses arriving at this point reach a critical level, there is a firing of the T cells that activates the neural mechanism of what is postulated to be a central decoding system. If the firing frequency of the T cells is low, the stimulation is interpreted as not painful, when high as pain. Because in this theory interpretation is necessary, the gate control theory of pain allows for a cognitive, motivational, emotional dimension in which pain experience is evaluated. The central control mechanism in the gate control theory would allow factors such as general excitement, emotion, attention, attitude, and prior experiences to exert control over afferent sensory input, modulating pain reception.

Fabrega and Tyma (1976a, 1976b), using evidence from neurobiology, hermeneutics, psychosomatic medicine, biomedicine, and epistemology, have portrayed how this emotional and cognitive modulation of pain might occur. They suggest that such modulation might involve ramifying connections between

peripheral pain receptors transmitting messages from sensory receptors to the central nervous system. In Fabrega and Tyma's model, messages are modulated in the central nervous system by hormonal, affective and perceptual processes, all of which are influenced by cultural categories and social relationships. Thus, more recent theories of pain provide explanations for how pain mechanisms can be affected by meaning, memories of past experiences of pain, current attitudes and expectations regarding pain, gender, ethnicity and culture. Since these theories have provided a place for psychological, social and cultural factors in the human experience of pain, it is important to conceptualize the human body in a way which will provide a vantage point from which to investigate these factors.

AN ALTERNATIVE APPROACH TO THE HUMAN BODY IN HEALTH AND ILLNES

The biomedical model has exerted a powerful influence on thinking about health, illness and the body in Western culture. A view such as that of the biomedical model can become so predominant and ubiquitous, so much a part of everyday experience, that it seems "natural". This not only makes it difficult to think in other ways, but can make it seem unnecessary to do so. Such apparent naturalness can obliterate the social and cultural activities underlying a particular way of viewing the world. As a person raised in a culture in which the biomedical model has dominated thought about the body, I appreciate how hard it can be to grasp the idea of the body as something other than an individual, objective, predetermined physiological object. However, as demonstrated in the previous

section, the human experience of pain appears, in large part, to elude the physiologically-based approach of the biomedical model, making pain a problematic area for biomedical treatment and suggesting the importance of an alternative view of the body as socially and culturally constructed.

In order to investigate the effects of psychological, social and cultural factors on human pain in this research, an alternative view of the human body is necessary. I will argue that the “naturalized” physiological body of biomedicine masks the social and cultural processes used in its construction. Moreover, this biomedical construction of the body is promulgated through discourses and activities which take place in physical places, including such cultural institutions as schools, churches and health care settings. As Margaret Lock reminds us, “when we relativize culture, self and identity, and health we introduce a reflexive approach...that ensures that we begin to understand how biomedical and psychological knowledge and practice are themselves cultural productions” (Lock, 1999, p.44). Moreover, Lock warns us that the biomedical model is rooted in Cartesian distinctions between mind and body, culture and nature, cognition and emotion. As she puts it, “Descartesian thinking is involved, the cultural world of the mind is set up in opposition to that of the body, a creation of nature” (Lock, 1999, p. 45). As a result, in the biomedical model, the body is dealt with as a physiological entity. Moreover, of particular importance to this study, these distinctions are often connected to gender. Frequently, females are associated with the body, nature and emotion, while males are connected with mind, culture and cognition.

A view of human embodiment as socially and culturally constructed

What does human embodiment look like when viewed from such an alternative perspective, when the body is viewed not simply as an individual, physiological object, but as socially and culturally produced and negotiated? To develop a description of such an alternative view, I will draw on examples from the range of bodily processes addressed in the literature supporting such a view, not only on pain. The goal of this description is to explain this alternative way of looking at human embodiment and how it can be used to investigate how social and cultural factors, along with personal life experiences, affect the meanings associated with experiences of the body and play a role in human physiology.

I will begin by discussing work on the relations between larger social structures and human embodiment, focusing on the work of Scheper-Hughes (1992), Scheper-Hughes and Lock (1987) Lock (1999) and Becker (1994). Their work explains how the body can be viewed as both individually and collectively experienced, as subject to regulation, discipline and control by larger political and economic forces and as socially represented in various symbolic and metaphorical idioms. In the following section, I will “delve deeper”, concentrating on the work of Csordas (1990, 1994), Good and Kleinman (Good, Brodwin, Good, & Kleinman, 1992; Good, Good, & Moradi, 1985; Good and Good, 1980; Good and Kleinman, 1985; Kleinman, 1986, 1980a, 1977, 1973; Kleinman & Kleinman, 1991) and Rosenwald (1992) to elucidate how the social representation of the body in symbolic and metaphorical terms might interpenetrate the somatic in a “mindful body”. In the current research project, this alternative view will be used to develop a rationale and

methodology for exploring a psychosocio-cultural understanding of gender differences in the perception of and tolerance for pain.

The three bodies, the body politic, the body social and the individual body, in culture, space and time

Scheper-Hughes and Lock (1987) present a conceptual framework which helps in understanding the relations between individual and collective experiences of the body in their discussion of relations among three bodies: the body politic, the body social and the individual body. They depict these three bodies as intricately interrelated in a network of everchanging attributions of meaning which affect the experiencing “mindful body”. The individual body refers to the “lived experience of the body as self” (Csordas, 1994, p. 5), the social body to uses of the body as a symbol of nature, society and culture and the political body to the regulation and control of bodies through social forces. This conception of the body provides a foundation for comprehending the intertwined contributions of psychological, social and cultural factors in the construction and experience of human embodiment. Lock argues for the importance of such a view for investigating human illness and distress when she says, “illness episodes must be integrated in the broader context of human relations, communications and politics. Only then can insight be gained into how social relations can produce illness and how the body functions, consciously and unconsciously, as a medium for the expression of distress, a subjective experience itself culturally mediated” (Lock, 1999, p. 44).

Scheper-Hughes (1992) uses the examples of food and hunger to explain the contributions made by social and symbolic anthropologists to our understanding of human embodiment. Social anthropologists have described the use of food by both individuals and social groups as media for complicated social relations, such as controlling others, establishing and maintaining sexual relations and avoiding or initiating conflicts. Symbolic anthropologists, through investigating the rich symbolic content in practice and language, have elucidated the ways in which food, food taboos and hunger are represented in terms of symbolic categories which organize social relations, order experience, and express and/or mediate contradictions.

Becker's (1994) depiction of the ways of experiencing and managing the body in Fijian culture provides an excellent illustration of this view. She describes the traditional, Fijian sociomythic view of the person, a view which has been severely challenged by the introduction of the Western concept of the separate, individual body. Traditionally, Fijians have viewed the body as located primarily in relationships, with the boundaries of the self extending into and inextricably interconnected with the larger social body of the community as a whole. She quotes Leenhardt's description of the traditional Melanesian he observed in the first part of the twentieth century who was "attached by all the fibers of his being to the group", and "not individuated, but diffused with other persons and things in a unitary, sociomythic domain" (Leenhardt, 1979 [1947], p. 164).

Becker goes on to explain that this traditional view of the individual body as inextricably interconnected with the larger community makes the individual body the responsibility of the group, rather than of the individual. In this social and cultural

milieu, the condition of each individual body is perceived as a reflection of the social network and its powers to nourish. For members of this community, in which feeding and caring for its members is a priority, an individual whose body appears malnourished is a reflection on the inability of the community as a whole, the larger social body, to provide adequate care and nutrition. Palpable discourses, in the form of a continuous rhetorical commentary, and numerous, interconnected, ordinary daily practices, in the form of food sharing rituals, reflect and perpetuate this traditional Fijian system of values. These discourses and practices occur systematically in real physical places in the culture, serving to both express and perpetuate the potent values accorded to care and caregiving in this cultural world. For example, in this community, body shape is carefully monitored and constantly commented upon as a part of daily discourse. To call someone “hungry”, within this socio-cultural and physical context, serves as a “moral indictment of someone who can neither provide food nor attain it through affiliation with a community” (Becker, 1994, p. 107). Becker (1994, p.107) also tells us that in the local idiom “hunger”, which translates roughly as “gone thin”, encompasses conceptions of a dissolution of social connectedness as the consequence of material and emotional deprivation which is made manifest in the individual’s bodily thinness.

In daily practice, Fijian families are obliged to throw open their doors and windows when serving food, in order to display the food and make it publicly accessible. People passing by must be greeted with cries urging them to come in and share the food. These invitations are compulsory, but usually rhetorical. Because of the great value placed upon sharing food and not eating alone, almost

all the people passing will be headed toward destinations where they have already accepted invitations to share food. However, should any passers-by accept the invitation, they would be genuinely welcomed and great care would have been devoted to earlier preparations, insuring that adequate food is available (Becker, 1994).

This traditional Fijian concern with individual body morphology stands in contrast to the extreme concern with body shape in contemporary U. S. society. Since traditional Fijians are concerned with the way in which the state of the individual body reflects on the prized social and cultural value of nurturing, they are not concerned with body shape for individual self presentation. Traditional Fijians do not regard body shape as a reflection of the individual person's predilections and worth. Their view stands in contrast to the contemporary Western concern with self presentation through the cultivation of specific types of individual body shapes, a view which is dominated by the Western conception of the separate, individual body. In the U. S. today, many Americans labor to achieve desirable, gender specific body shapes in order to exploit their representational capacities for conveying personal qualities of the self. While thinness for Americans often represents self discipline and responsible personal care of the body, the traditional Fijians whom Becker and Leenhardt describe are less concerned with cultivating the body as a marker of personal attributes. In the traditional Fijian culture, any evidence of weight loss is assumed to reflect a disruption in the cohesiveness of the social milieu, because, for these Fijians, embodied experience is not contained individually, "It is social not personal identity which is concretized in anatomic space" (Becker, 1994, p.108).

Social constructivism and the “critical disruption” of the 1970's

This perspective on human bodily experience, in particular the human experience of pain, as a social and cultural construction rather than as a pre-ordained, physiologically-based, unchanging reality, is referred to as social constructivism. Social constructivists view human experience of both the body and the external world as a sociocultural construction. For example, Michelle Zimbalist Rosaldo and Louise Lamphere (1974) contend that human physiology “requires human culture”, that humans may differ from other animals chiefly because they have the capacity to interpret and, perhaps, even alter, their biological constitutions, using the media of such symbolic forms as language. Social constructivists argue that human activities and feelings are not organized directly by biology, but by the combination of biological propensities with culture-specific expectations, plans and symbols. Due to the influence of such symbolic forms, it appears that humans are not subject to the same sort of behavioral programming as other animals. Social constructivists also maintain that humans do not encounter an external world in which categories and meanings are already determined. They argue that the categories and meanings humans need to grasp “reality” and function in the external world are co-constructed by humans through the practices and discourses of their everyday activities in social groups. The daily discourses and practices in Fijian culture presented by Becker provide an excellent example of this view.

Much of the power of Becker’s description comes from its realism. Through her vivid descriptions of the discourses and practices which occur in the course of

daily life, she helps us picture what actually takes place in this Fijian community (Becker, 1994). Leenhardt's perceptive descriptions of the traditional Fijians' sociomythic view of the body, the community and the relations between them make it possible for us to comprehend their phenomenological bodily experience (Leenhardt, 1979 [1947]). However, do all members of this culture share the same experience of the body, the same practices and views, or are there differences due to age, gender or social status?

Holland (1997) alleges that, in the 1970's, a "critical disruption" of the social constructivist view gathered force, resulting from a three pronged critique of the relation of anthropology and the other social sciences to its subjects. Prior to this critical disruption, anthropologists tended to view culture as a unitary entity which was evenly distributed across all members of a given culture. Culture "writ large" belonged to the community at large, while the same culture "writ small" belonged equally to each individual member of the culture (Benedict, 1923). Both universalists, who viewed the self as a natural, invariant, physiologically-based, species-given structure and the culturalists, who thought that the self was an entity created entirely by culture, shared this view of cultures as univocal entities with discrete systems of meaning, shared equally by all members. This critical disruption, which affected anthropology and other social scientific fields which dealt with the relation between culture and the self, required a reformulation of the way in which these disciplines construed relations between self, culture, place and health, both making possible and necessitating changes in methodology which are important to the current research.

First, critics, argued that all members of the culture did not share equally in all practices and discourses. All members of a culture do not have equal power. These critics, especially Feminists, contended that this assumed equality masked the overemphasis and privileged status accorded to males, male activities and masculine accounts of the culture. Multiple perspectives are present in every society and culture, with the practices and voices of some members holding greater power than those of others.

Moreover, these critics argued that social scientists not only paid too little attention to relations of power in the daily lives of the people being studied, but also to the unequal power relations embedded in their own role as researchers. Prior to this critique, both universalists and culturalists believed that individual selves could be investigated by the “objective observer” of positivist scientific inquiry, an observer standing completely apart from the cultural system, isolated from the phenomenon he or she sought to investigate. However, critics argued that social scientists are not unbiased observers, but both shape and are shaped by the interests and influences of the everyday world. Holland credits Foucault (1979) with demonstrating the way in which post-Enlightenment disciplines actively constructed rather than simply studied their research subjects. Foucault pointed out that scientific discourses placed people in categories which entered into everyday discourse, consonant with what Giddens (1991) calls the “reflexivity of the institutions of modernity”. As a result, these supposedly unbiased, scientific categories influenced the way people regarded both themselves and each other in everyday life. Moreover, these categories determined the sort of treatment they would receive in centralized

institutions. Critics argued that this traffic between scientific and popular discourses refuted the idea of objective scientific knowledge and of social scientists as non-interfering, truth-telling, objective observers

Finally, critics argued that social scientific disciplines represented the “others” they studied as though they existed in a timeless, unchanging present. However, they contended that, because cultures contain multiple perspectives and voices which are engaged in ongoing negotiations with each other, change can and does occur over time. Due to the ongoing interplay of these competing perspectives, cultures are not coherent, timeless, integrated wholes, but contested fields of struggle and protest. Critics urged researchers to acknowledge that a group of people was being studied at only one particular historical moment.

Active construction of “self”, “ identity” and the “body” using the “living tools” of practices and discourses in real places and times

Following this critical disruption, it was no longer possible to continue to view individual selves as miniature, passive reflections of the larger culture. Researchers began to think that “self” and “ identity” had to be actively constructed and were maintained or changed through involvement in social practices and public discourses. Ethnographies grounded in this new perspective began to devote attention to the “self in action” or the “authoring self”. In addition, the post-disruption social constructivists began to view the system of meanings for a given social group as co-constructed and negotiated by its members through actual practices and discourses, which take place in real settings in the physical world. Rather than

viewing cultural practices and discourses as indicators of an underlying, pervasive culture, social scientists began to realize that they could more usefully be conceptualized as “living tools” which individuals and groups use actively to construct their experience. Using these “living tools”, members of the group, operating from different perspectives, negotiate to construct knowledge and the meaningful world as it will exist for that cultural group. Since the participants engaged in such negotiations exercise varying amounts of power and influence, participants are able to negotiate varying amounts of meaning relevant to their own lives.

From this new viewpoint, particular people living in definite places use socially and culturally negotiated discourses and practices to connect the larger cultural context and its institutions to their inner experiences. Thus, the tools which the self uses in this construction are not considered to be randomly available. From this new perspective, the embodied human is viewed as having access to certain practices and discourses because of the places made available in the society, to which specific types of activities are allocated. Different individuals within a given culture have access to a range of the practices and discourses available within that culture based on the physical places to which each individual can attain access (Holland, 1997).

David B. Morris (1991) emphasizes how important the time and place in which people live is to the ways in which bodies can be constructed in his depiction of the changing nature of the experience of pain across historical time. For example, some ancient cultures viewed pain as supernatural, caused by evil spirits.

Sometimes trepanation was used to provide these evil spirits with a way out of the head (Morris, 1991). Christians in medieval times explained pain as penance and contrition for original sin (Bowker, 1972). For them, pain possessed spiritual value and offered a form of contact with divinity. In contemporary Western cultures, efforts have been made to explain pain strictly in terms of the physiology of the human nervous system (Clark, 2001). However, Morris cautions us that this view, too, is subject to change, saying “social responses to pain will not remain unchanging because society rarely stands still” (Morris, 1991, p. 55). As Morris explains, the “peculiarly changeable nature of pain” (Morris, 1991, p. 37) makes it necessary that we learn to understand this oldest and most personal of human experiences as inescapably influenced by the specific time and place in which it occurs, making pain not a strictly biologically determined occurrence, but “an experience in search of an interpretation” (Morris, 1991, p. 38). Because of its significance in human life, Morris maintains that “pain is almost always the occasion for an encounter with meaning” (Morris, 1991, p. 34), meaning which will be constructed through the practices and discourses present in a particular culture

Thomas Csordas (1994) cites the considerable body of work which indicates that “the body has a history” (Bynum, 1989, p.171). Just as we have seen that pain has a history and changes across space and time, the human body behaves and is experienced and treated differently at different historical moments (Frank, 1991, p.40). For example, Foucault has identified how the goals of bodily self care have changed from spiritual salvation to enhanced health to the creation of a marketable self (Foucault, 1986; Bordo,1990). In her work on Fijian culture, Becker (1994)

demonstrates how the cultivation of the body differs across contemporary cultures, as well.

Csordas also argues that, at this historical moment in Western culture, it is becoming increasingly difficult for people to regard our human bodies as simply brute “facts of nature” or as “fixed material entities subject to the empirical rules of biological science, existing prior to the mutability and flux of cultural change....and characterized by unchangeable inner necessities” (Csordas, 1994, p.1). As Emily Martin (1990) has commented, the current, widespread academic interest in the construction of the human body might be due to the “fundamental changes in how our bodies are organized and experienced”(Csordas, 1994, p.1), which humans undergo with increasing frequency in contemporary life, changes so drastic and rapid that people are actually aware of them as they occur. Humans living in contemporary, Western industrialized societies have frequent, daily experiences in which the boundaries between human and machine, human and animal, and physical and non-physical are breached, making the ambiguity of the boundaries of human corporeality obvious.

Kleinman and Good's alternative perspective on human health and illness

The work of Byron Good, Arthur Kleinman and their colleagues has been important in the development of an alternative view of human bodily experience which takes into account psychological, social and cultural factors. They have used this embodied perspective in their investigations of the roles of gender and ethnicity in human health and illness at the Harvard School of Public Health (Good et al,

1992; Good et al, 1985; Good and Good, 1980; Good and Kleinman, 1985; Kleinman, 1986, 1980a, 1977, 1973; Kleinman & Kleinman, 1991). Like Rosaldo and Lamphere (1974), Good and Kleinman hypothesize that, for humans, “culture is constitutive of experience” (M. J. Good, et al., 1994, p.9) and symbolic forms are “constitutive of reality” (M. J. Good, et al., 1994, p.9), which means that human suffering and disease are not simply biological givens but exist very much “within culture” (M. J. Good, et al., 1994, p.10).

The studies of depression which Kleinman (1977, 1982) conducted in China, provide an excellent illustration of this view of human suffering and disease as very much “within culture”. In his work in China, Kleinman, who is trained as both an M.D. and an anthropologist, noted differences in the ways Chinese patients described their experiences of a disorder which seemed to fit the Western biomedical classification of depression. Early in his work, he hypothesized that the differences he observed were differences of description and interpretation, caused by viewing the same physiological phenomenon through the lens of a different culture. He thought that people regarding experience through different cultural lenses focused greater or lesser degrees of attention on different aspects of the same, physiologically- based experience. However, as his experience working with Chinese patients increased, he began to think that the differences he was observing were not simply differences in the interpretation of the same physiological experience. He began to think that the depression he saw in his Chinese patients was in many ways a different entity, even at the physiological level, that culture

constituted the physical body in ways sufficiently different to alter the physiological dispositions of the human body.

The perspective Kleinman and Good take involves an epistemological stance which is fundamentally different from that of biomedicine. The epistemological stance inherent in the biomedical model is that an objective stimulus exists in the external, physical world. Pain reports refer to this external stimulus with greater or less verisimilitude. However, Kleinman and Good view symbolic forms as organs which serve to constitute or construct reality, not as imitations or reflections of reality, nor as tools which straightforwardly mediate between an objective and a subjective world. In the midst of the limitless stimuli which the world presents to humans, Good and Kleinman maintain that intersubjectively constructed symbolic forms have a formative influence on human bodily experience and on what humans apprehend as real and available to human acting and knowing. For Good and Kleinman (Good, 1994), language and practice play essential roles in this social and symbolic construction of reality.

Worthman (1992) offers a view, based on her work as a cultural biopsychologist, of how symbolic forms may interpenetrate the physical body. In her discussion of the importance of cultural biopsychology as a field in which the operation of the person-body-culture dynamic can be elucidated, Worthman like Kleinman and Good, contends that our current understanding of the workings of the nervous system are inconsistent with the idea of the direct perception of a fixed, pre-interpretive sensory reality which exists independently of culturally and/or historically shaped interpretive schemata. She argues that there is strong evidence that much of

the fine structure of the brain arises with experience, apparently produced through a process of stimulus reinforcement and pruning. The reception and processing of information during the course of daily living serve to actively configure neural circuits and larger functional complexes, such as association and memory (Changeux, 1985; Edelman, 1987, 1991).

Worthman goes on to point out that a great deal of work in the field of psychological anthropology has been devoted to cross cultural studies of the influences of childrearing practices on both the psychosocial and physical development of children. These studies have identified direct effects of the culturally prescribed prenatal and perinatal behaviors of parents on not just the physical, but also on the psychological and cognitive, development of children. At conception, the human organism is endowed with genetic potentials that are already interacting with the organism's environment. It appears that, in humans, boundaries are set and patterns established that enable some details of structure and operation to emerge, but not others. Since some aspects of human development are not pre-programmed, humans have a greater flexibility and can adapt to a wider range of environments, which has served as an evolutionary advantage. Because there are un-programmed aspects to human development, psychological, social and cultural factors play an important role in the constitution of human physiological functioning.

Spitz (1950) observed that infants being raised in an institutional setting, in which they received adequate food and shelter, but were rarely, if ever, handled and played with, failed to thrive. They identified a syndrome, "institutionalized dwarfism", in which children failed to thrive both physically and emotionally when deprived of

interpersonal stimulation, offering further support for the contention that the interpersonal and physical realms interpenetrate each other.

In search of the “mindful body”, the “ body as the existential ground of culture and self”

Scheper-Hughes (1992) stresses the importance of a holistic model which views bodily distress, such as hunger and pain, in terms of the inseparable, inner, phenomenological experience of the suffering human. She protests that, while the work of symbolic anthropologists has captured the rich interrelations between bodies and social forms, these researchers have removed themselves from the level of “plain facts of [hunger] as a lived experience” (Scheper-Hughes, 1992, p. 224). This has resulted in a viewpoint from which the idea of an integrated “mindful body” has been lost., leaving us with a “disembodied view” of human bodily experience (Scheper-Hughes, 1992, p.224). Thomas Csordas (1994) elucidates how the body came to occupy such an objectified position and offers a way back to the “mindful body”. He calls for and delineates a shift in perspective which will change the view of the body that of an empirical object or analytical theme to being considered as the existential ground of experience itself. He argues that such a shift in perspective offers a critical methodological opportunity to reformulate theories of culture, self and experience with embodiment as the center of analysis as “the existential ground of culture and self”(Csordas, 1990, p. 6), a methodological reformulation which is important to the design of this research.

This new perspective on the body as the existential ground of culture and self is in keeping with the stance taken by Marcel Mauss (1950). Mauss argues that the body has been regarded only as the biological ground on which the mind operates. This perspective on the body excludes it from original participation in the domain of culture and reduces the body to a pre-cultural substrate. Mind becomes the subject, with body becoming the object upon which the mind operates. However, Mauss explains that the body is not just a pre-cultural substrate. Our bodies are not always, nor are they originally, objects to us. The body is both the original tool with which humans shape their world and the original substance out of which the human world is shaped. Viewed in this way, bodies are the ground for perceptual processes that end in objectification. This means that bodily being in the world exists as a pre-objective experience.

Csordas (1994) offers a critique of representation which helps us view the body as the source of subjectivity and the mind as the locus of objectification. His critique both illustrates how a dualistic bifurcation of mind from body is constructed and offers us a way out of this dualistic construction. He observes that objectification is a product of reflection (Csordas, 1990, 1994; Merleau-Ponty, 1962). Depending on one's standpoint, either mind or body can be construed as subject or object. However, when the body is objectified, one possible consequence is that it creates a dualistic conceptualization of the human in which mind and body are placed in opposition to each other. Csordas objects to the dominance of representation as an epistemological modality. He argues that the dominance of representation over experience polarizes language and experience, saying that this

view of representation prioritizes concern with the problems of representation over the problems of being in the world. The dominance of representation allows semiotics to dominate over phenomenology. He maintains that when representation is allowed such domination over immediate, phenomenological experience, one is left studying only language or discourse, which amounts to studying only representation. Csordas challenges this dominance of representation and argues for the existential immediacy of bodily experience and the re-inclusion of agency and identity.

Csordas goes on to explain that, while people who espouse the study of “experience” often meet with the objection that one cannot study experience because all experience is mediated by language, this is merely the result of the polarization of language and experience produced by a predominantly representationalist theory of language. It is possible that language is neither about nothing other than itself nor that it is entirely constitutive of experience. There is a middle ground. Csordas argues that language can give access to a world of experience both insofar as experience comes from language and insofar as experience is brought to language. As Heidegger (1962) points out, language not only represents or refers to, but discloses our “being in the world”.

Finally, Csordas explains that when one abandons the view of the biological body as a monolithic objectivity, the body is transformed from object to agent (Haraway, 1991, p.198; Frank, 1991, p. 48). and the body as an experiencing agent becomes evident. This view of the body as agent has been prevalent in recent work in the social sciences on the experience of illness, (Good, 1994; Kleinman, 1998;

Lock and Dunk, 1990; Ots, 1991), on body image (G. Frank, 1986) and, most importantly for this research, on pain, (Good, et al., 1992). Thus, Csordas provides a view of human bodily experience in which the direct experience of the human body and its needs encounters and interacts with the discourses and practices of culture and society, bringing into being forms of human embodiment. Rosenwald (1992) helps to extend this discussion, addressing the issues of agency and subjectivity and developing a more extensive theoretical formulation of the ways in which the body and practice relate to narratives and life stories. In particular, he clarifies that there is a difference between the self, the story and the situation.

Narratives, lives, contested realities and situated experience

Narratives constitute an important element of the current research. Narrative theorists argue that narratives and life stories “play a significant role in the formation of identity” (Rosenwald, 1992, p. 265). Bruner (1986, 1990) describes narratives as essential meaning-making tools which allow humans to draw on past experience in order to evaluate current circumstances and formulate expectations of what will occur in the future. Similarly, Polkinghorne (1991) turns to narrative to explain the human construction of self. He emphasizes the dramatic, temporal dimensions of human existence, saying that selves are more like narratives or stories than substances. The operation of narrative serves to configure the diverse happenings of a human life into a meaningful whole. Gergen (1994) argues that humans must draw on the rhetorical conventions of their time in order to formulate the narratives which allow them to make sense of their pasts and make their internal processes

intelligible. However, Gergen also points to the difficulty inherent in this view, sometimes referred to as “textual essentialism”. The problem is that, in the textual essentialist’s view, the available discourses of the time completely shape and account for the self.

Similarly, Rosenwald (1992) explains that personal life stories draw on the rhetorical conventions available in society. These stories both communicate the teller’s values and commitments to others, and, at the same time, reflect the same values and commitments back to the teller. Becker’s description of Fijian practices and discourses regarding food, which occur in everyday life, provide a good illustration of this. Traditionally, Fijian discourses on body shape and practices involving food sharing serve to both express and perpetuate the importance of care and caregiving in this social and cultural milieu. Since the political, social, and power relations specific to a society are inherent in the conventions of its practices and discourses, in both the telling and the reflection of this telling back to the narrator, the teller becomes more strongly bound to the societal values on which the story depends. This process serves to further reinforce these values, strengthening the socialization of both acceptable behaviors and acceptable accounts of behaviors. Moreover, the matter of fact, everyday quality of these discourses serves to make them seem “natural” making them even more powerful in reinforcing and renewing extant values, practices and power relations.

Rosenwald (1992), like Gergen, points out that, according to such a “strong constructivist” or “textual essentialist” view, people are completely constrained in the way they tell life stories by the models of storytelling which are available to them in

the societies and cultures in which they live. In any culture, only certain types of stories are evaluated as intelligible and acceptable accounts of a life. Since “textual essentialists” argue that texts are all there is, in their view, the individual’s story must be a reflection of social conventions in every detail. The presence of such accepted forms of storytelling explains how culture-specific discourses work to stabilize a culture. However, while Rosenwald notes that narrative theorists seem to agree that narratives and life stories can be both “constrained by oppressive cultural conditions” and, conversely, “liberated by critical insight and engagement” (Rosenwald, 1992, p.265), both Rosenwald and Gergen argue that this “strong constructivist” view of narratives and life stories makes it difficult to understand how change can occur in either the culture or the individual person’s story. Rosenwald notes that in the self-perpetuating situation depicted, in which stable patterns of acceptable discourse represent and reinforce extant, dominant forms of social structure, it is difficult to account for both social change and personal agency. Rosenwald’s explanation of how change is possible involves an excellent, and necessary, theoretical development of the relation between narrative truth and practice.

Rosenwald extricates us from this dilemma by pointing out that, while the individual in any society is constrained by the practices and discourses specific to that society, individual compliance with these constraints is never total. Such compliance represents a compromise on the part of the individual. Individuals comply with extent, stable practices and discourses because they provide a way of ordering the individual’s world, helping to maintain stability for both the individual and

the culture. However, as Rosenwald explains, the desires of personal subjectivity extend beyond the temporary constraining compromises imposed upon them by the forces of socialization, limiting some of the individual's desires and goals. Because the individual's life trajectory is governed not just by the acceptable practices and discourses of the society, but also by the desires of the individual, tensions can arise between the storyteller's desires and the culturally available stories. It is when the person's life experience pushes her or him, when something seems greatly in need of expression that goes beyond what the accepted discourses can contain, that individuals are stimulated to critique, innovate and invent, to tell stories that violate societal boundaries and cultural rules for storytelling. As Rosenwald (1992, p. 266) puts it "by undoing compromises, the subject again and again takes the risk of violating models of intelligibility." The individual storyteller is likely to risk rejecting the narrative compromises which maintain a balance between that individual's desires and the stabilizing conventions of the society in situations where the complexity of individual human experience tests the limits of the routinized thought of everyday talk.

Rosenwald cites racist and sexist language in our own culture as examples of social discourses which individuals have been driven to violate because the tensions between the individual's needs and desires and the social conventions on which she or he must draw for models of intelligibility have become too great to be maintained within conventional social discourses. When the narrator becomes aware that these narrative conventions are too constraining, that they have become problematic in the face of the teller's daily, lived experience, narrators are especially likely to become

aware of and violate narrative conventions. Rosenwald argues that change and social development are promoted not by the conformity of narratives to social conventions, but by situations such as these, in which tensions between person and story make change possible and, perhaps, inevitable. Such situations illuminate the ways in which societal conventions underdetermine the stories people tell about themselves. A key point for the purposes of the present research, which Rosenwald makes here, is that such breaches of socially conventional stories are possible because there is a difference between the self and the story. The self is not totally encompassed by the story

The relation of the narrating subject to both his or her stories and to the situation in which these stories are produced is important to this research and needs examination. The post-realist position is that it is not possible to recount one's past more or less accurately because narrative is not concerned with accuracy. It does not portray an objective state of affairs nor, even, a private, psychic state of affairs. However, since post-realists reject the possibility of the faithful representation of a pre-existing external or internal reality at any time, past, present or future, it is difficult to determine what the life story can be taken to represent or mean. As a result, life story narratives are sometimes viewed as fictions because it seems as though, in a post-realist world, people can say whatever they please about themselves and their lives as long as they remain within the boundaries the society has set for what constitutes an acceptable account of a life. As Rosenwald (1992, p.269) phrases it "constructivists treat a teller as a construction projected on the

basis of a conventionally accepted tale.” As Rom Harre (1989) puts it “People are what they believe they are.”

It certainly seems unacceptable to assume that people are whatever they tell stories saying they are. However, without faithful representation as a criterion for evaluating personal accounts, it is difficult to know how to consider life stories. If stories are not repositories of objective information, what are they and about what, if anything, can they provide information? What can they be taken to represent? If researchers interested in the development of lives gain access to these lives through people's stories about them, what information can these stories provide? These questions get to the heart of Rosenwald's critique. He argues that the theories of the textual essentialists conflate narrator, narrative, and narrative situation. As a result, textual essentialists don't allow for a critique of social, political and psychological impediments to human self comprehension and development, nor for a critique of social conventions. If a life is no more than a story and the story is wholly governed by the situation in which it is told, what can we hope to learn about a person from her or his stories? Moreover, Rosenwald cites Wrong (1961) who argues that this represents an oversocialized view of personality.

Rosenwald solves this dilemma by contending that narratives display the mediation between the person and the situation. In addition, because they are not reducible to each other, narratives and life stories reflect critically on both the person and the situation. Thus, it is not necessary to assume that narrators represent their lives accurately. The important point for purposes of analysis and understanding is that life stories are meaningful to people's lives because the stories people tell play

an important, mediating, role in the lives narrators are recounting and trying to live.

This is because life story narratives are not only about the life but are part of the life.

Because life stories play a role in their lives, narrators are not indifferent to their accounts, but struggle to tell their lives correctly, the way they believe them to be.

Rosenwald calls this “double relevance” and argues that this double relevance, being both about the life and part of the life, gives narratives “their cognitive and motivational power to transform lives” (Rosenwald, 1992, p. 271). A peculiarity of human life is that it is constantly becoming, as Heidegger (1962) put it “dasein is thrown.” Any given life story contains a potential impulse to future development.

When people tell stories about themselves, these stories merely represent momentary stopping places in the life trajectory. The narrator’s orientation to the past serves to reorient his or her present to certain futures. Moreover, as Bruner (1990) has pointed out, human lives do not move along seamlessly. Narrators must constantly revise their narratives to accommodate the unforeseen circumstances which inevitably arise in the course of daily life. This view contrasts with the essentialist view, that there is some basic underlying “self”, which can be arrived at by peeling away layers of falseness.

Rosenwald (1992) terms this constant becoming “historicity” or “ historicism” and points out how essential this “becoming” is to the study of human lives. Historicism carries with it the implication that the meaning of any moment in the development of a given life can best be understood through consideration of the effects of moments earlier in the life, which survive and are present in the narrator’s current interpretations of her or his experience. Rosenwald illustrates “historicity”

with Freud's (1918) well known ideas about the effects of infant sexuality on the adult. According to Freud, the individual is never wholly freed from these early experiences, because they continue to play a role in who he has been, influencing, but not determining, who she or he can become. In addition, Rosenwald contends, we can also understand the meaning of past moments in the narrator's life by looking at what happens subsequently, in both the narrator's later stories and in her or his later life. Thus, Rosenwald argues, since stories are a part of life, not removed from it, narrative and practice influence each other.

Rosenwald concludes by pointing out that historical truth, in a post-realist world, is not a claim limited to the accurate reconstruction of the past, but lies in the possibility of understanding accounts of the present as transformations of past accounts. He criticizes theorists such as Spence (1982) for discarding more of the claims made by realists than is merited. While Spence takes the position that the historical past is not only empirically irretrievable, but also theoretically irrelevant, Rosenwald embraces a new theory of narrative truth which still repudiates narrative as an accurate account of a veridical past, but retains a life historical approach to meaning. Rosenwald argues that the validity of a narrative can be judged by the new cycle of stories and consequences it generates. Because we, as humans, must stop to take stock of our past development before we can move on, stories can not only follow events in life, but can precede them, which Rosenwald terms "new living action" (Rosenwald, 1992, p. 273). Rosenwald further clarifies the relations between narrative and living action, saying that the distinction between telling and living is not categorical. Outcomes are evaluated by how they are told. Consequences

constitute no more of a basis for evaluation in themselves than do narratives. For example, a narrator's claim to a cure for an experience of illness is evaluated as credible only if it can be seen to relate to and evolve out of the illness account it transforms. In addition, the evolution of more "satisfactory" accounts of daily life correlates with enhancement of the behaviors and forms of relatedness of which the narrator is capable in the activities of daily life conducted in the real, physical world. Rosenwald offers the example of the analysand in therapy who develops a wider range of behaviors and a greater tolerance of affective expression and experience through the reconstruction of his narratives and life stories. Rosenwald also offers the example of a "good conversation", which is judged good not because it mirrors reality in every particular, but because the speakers wish to continue it, because the dialogue has turned into an opportunity to understand themselves and their place in the world differently and more fully.

Thus, for Rosenwald, telling and living extend and alternate in time, constituting a kind of causal chain, but a causal chain that does not unfold inside a closed system. Innovations in living depend on more than just the narrator. This means that activities can be restricted by power relations and the costs of explorations in living, while narratives can be restricted or aided by the presence or absence of opportunities for reflection and discussion at both the individual and collective levels.

PLACE, PRACTICE AND THE DESIGN OF THIS STUDY

Morris points to “the peculiarly changeable nature of pain” (Morris, 1991, p.55) explaining that the changeable nature of pain makes it necessary that we realize that pain cannot be viewed as a strictly biological occurrence, but is an “experience in search of an interpretation” (Morris, 1991, p. 38). He emphasizes that this makes it essential that we try to understand the human experience of pain as inescapably influenced by the specific place and time in which it occurs. Moreover, Morris alludes to the socially negotiated construction of pain when he says “social responses to pain will not remain unchanging because society rarely stands still” (Morris, 1991, p. 55). Finally, Morris maintains that the significance of pain in human life assures that “pain is almost always the occasion for an encounter with meaning” (Morris, 1991, p. 34), meaning which will be constructed through the practices and discourses present in a particular culture. Because of these three characteristics of the human experience of pain, its changeable nature which make it different across places and times, its socially negotiated construction and its significance in human meaning-making, the human experience of pain is a uniquely appropriate “portal” for a place-based investigation of the ways in which women and men construct their embodied experience.

Several theorists whose work has been discussed have stressed the importance of a situated, place-based approach to research on the embodied human. Thomas Csordas (1994) cites the considerable body of work which indicates that “the body has a history” (Bynum, 1989, p.171). Just as we have seen

that pain has a history and changes across space and time, the human body behaves, is experienced and is treated differently at different historical moments (Frank, 1991, p.40). Nancy Scheper-Hughes (1992) highlights the importance of situated studies when she argues that it is important to ground research on human embodiment in the daily, lived experience and real, local worlds of the specific people being studied. She emphasizes that, since people live at a particular time and in a specific place, their experience cannot be studied effectively outside this context of daily living. Lock argues vehemently for this approach and articulates the importance of attention to practices, when she says, “Accounts of actual practices, not theoretical abstractions, should provide the starting point for specifying context. The goal then becomes establishing the effect of knowledge at local sites, the legitimacy of competing knowledge claims and, above all, the impact on the lives of those people most directly affected by the resulting practices” (Lock, 1999, p. 43).

Csordas also expresses concern that experience, discourses and practices which take place in real physical places and at specific times form the basis of research on human embodiment. He cites Haraway’s argument that “the appropriate alternative to the naturalized and essentialized body of biology is not relativism, a view that denies embodiment by being located nowhere while at the same time claiming to be located everywhere equally” (Haraway, 1991, p.191). Rather, the appropriate alternative to the biologically essentialized body is one that emphasizes location because by emphasizing location, one “accepts the interpretive consequences of being grounded in a particular embodied standpoint-the consequences of relatedness, partial grasp of any situation and imperfect

communication.” (Csordas, 1994, p.2). From such a specific, embodied standpoint, it becomes apparent that embodied humans occupy non-equivalent positions in the society’s web of interconnections. Any given embodied human has access to only some discourses and practices, which are unique to the experience of that individual. This attention to lived experience and to actual practices and discourses as they occur in people’s physical, local worlds plays a key role in the design and construction of the current research.

The theory of “structuration”

The theory of “structuration”, drawn from geography (Pred, 1985, 1984, 1983), states that people do not conduct social relations at random in an undifferentiated external world. It offers a perspective from which to conceptualize how to investigate the situated practices and discourses which women and men use in constructing their experiences of pain. From the standpoint of structuration, geographers argue that discrete forms of social interaction take place selectively in certain places to which some groups of people have access, while other groups of people are systematically excluded. Moreover, Pred argues that, according to the theory of structuration, place is intimately related to human activity because people appropriate and transform space and nature in processes which are inseparable from the reproduction and transformation of society in time and space. Since there is only a limited amount of space available in any society, space is apportioned based on the values, beliefs, and psychology of the decision- making and action-taking population. Based on dominant evaluations of what is most important to the

social group, places are created to which various forms of social interaction are restricted.

Pred (1983) also explains how the theory of structuration accounts for how power relations affect what people do and know. He points out that power relations operate in concrete ways in terms of actions and everyday practices, determining who does what, where, how, and with whom. Knowledge is transmitted and obtained through time-space specific practices. Since certain types of knowledge are only transmitted or discussed in certain places, with certain groups of people present and other groups of people systematically absent, individuals have differential access to forms of knowledge. Moreover, the power relations involved in the creation of places are, themselves, transformed and reproduced by the routine, and occasionally non-routine, practices which occur in places, affecting which places are maintained and which are transformed or eliminated. Thus, like the self, places are actively maintained or transformed.

Pred (1983) illustrates how these ideas might operate at a more functional level through his portrayal of the dialectical relationship between the Daily Path, the course the individual takes in the conduct of his or her daily life activities, and the Life Path, which is the overall pattern of possible projects to which space is allocated in a culture or society. Pred contends that these socially and culturally determined possibilities guide the trajectory of the individual's life across its entire temporal span. For this reason, an individual's Daily Path is not randomly determined. It is highly structured by the overall values, beliefs, and goals of the culture in which the person lives, which are concretized in physical space. Social and cultural values,

beliefs and goals govern the places the person may and will go in the course of daily life, influencing the ways she is allowed to place herself within this social and cultural milieu. Thus, both the Daily Path and the Life Path are systematically embedded in the midst of these larger sociocultural forces because they “take place” in specific, socially and culturally determined, places. As Pred describes it “In any becoming place, certain institutional projects are dominant” (1985, p.341). Such projects, usually by mutual, unspoken consent, make demands on time and space resources which are limited, and, thus, exclude activities associated with other, less valued, projects. They influence what can be done and known, and they account for the most significant path-project intersections. At one and the same time they are the source and outcome of power relations within a place.”

Spivak, (1965) based on his work in mental hospitals, offers a good example of how such selective access might affect the self's work of identity construction. Spivak noted that within a mental institution, a “mentally ill patient” has few options regarding how to place herself in relation to other people in the environment. Her presence in a mental hospital in the role of patient means that people who encounter her there will relate to this aspect of her identity. Thus, both her physical and social placements tend to reinforce the identity of “mental patient”, while making other aspects of her identity less salient and even problematic. Moreover, many settings for interactions with others, many other possible sites for self-construction, which are open to non-inmates, leading “normal lives”, are missing from her everyday environment.

Spivak says that he has occasionally observed patients in the other settings to which they have access in mental hospitals, such as while swimming. He has noted that, given a chance to engage in activities that tested their competence, worth, and identity, they momentarily behaved and looked like healthier people. Spivak also points out that, should the patient's "illness" become worse, the range of different settings open to her would be likely to decrease even further. Thus, the sicker she is, the more she is confined, the more she is confined, the sicker she seems.

But, how should place be regarded at the current time? Due to technological innovations, many people move from place to place and even from culture to culture. Many such moves across space and cultures may take place in a person's life. In some cases, whole groups move, in others, individuals or small groups move. At this time, in the contemporary, post-modern world, it is not always possible to interview people in the single settings in which they have lived their whole lives. Moreover, what Lock refers to as "contemporary participation in a pluralistic society" (Lock, 1999, p.45) means that influences from distant places can affect local practices and discourses. As Lock puts it, today, "the borders and boundaries dividing the world are in a permanent state of flux and transition" (Lock, 1999, p.46) adding more complexity to the range of voices present at any place in a contemporary, pluralistic society. Appurдай (1990) argues that "the global economy" must be interpreted as a "complex, overlapping, disjunctive order". In order to deal with this complexity, in the present research, participants are asked to construct the places in their lives in which interactions concerning pain have taken place. This

provides an opportunity for research participants to present constructions of their experiences of pain in everyday life which may have occurred in locations which span huge distances.

Investigating practice in place

The idea of “practice” is important to this research. Rosenwald (1992) has demonstrated that narratives and life stories are intrinsic parts of lives because they are not only about the life but are part of the life. Becker’s work (1994) illustrated how both practices and discourses which occur in places shape bodily experience.

Bourdieu (1977) explains practice in terms of joint action and collective activity. Bourdieu also asserts that practices are changed or maintained by an active process, they don’t merely stay the same due to lack of use. This conception of practice makes it possible to investigate activity in the physical environment between embodied human beings in a manner parallel to the examination of narrative. Both can be viewed as areas where active social construction takes place. This perspective on practice also helps to move explorations in this area away from those which are based solely in language. From a theoretical perspective, it is even possible to view the realms of practice and discourse as overlapping and mutually influencing each other. Roger Barker (1968), in his later work, describes the flow and organization of activity in units demarcated in a way very similar to those used by narrative theorists, in terms of their meaning in pursuit of goals important to the individuals engaged in the activity. Conversely, Searle (1983), in his conception of Speech Acts, views speech as reconstituting the state of things in the world in

substantive ways. For instance, when one takes a vow or christens a ship, these actions serve to reconstitute relations among people and things in the world in powerful ways. In most societies, when two people take a vow of marriage, places and spaces are re-apportioned and webs of relationships are reconfigured. Conferring knighthoods is another simple example of this, in which a speech act results in many practical differences in behaviors and rights.

Giddens (1991) provides some excellent examples of how culturally conditioned practices vary across time and place in his discussion of “technologies of the self”. These are culturally conditioned practices which vary over time and influence the types of selves which it is possible for an individual to construct in a given culture. For example, in the twelfth century, confession was a technology of the self, in the twentieth century, psychotherapy.

A central issue in the relation of “practice” to narrative in research on health is well illustrated by Good’s (1994) discussion of the translation of symbolic forms from one culture to another. Good argues that adequate translation requires the interpretation of symbolic elements in relation to a field of signs. Because cultural symbols attain their meaning and significance relationally, through their opposition to and correspondence with other symbols, one cannot simply substitute item A from culture 1 for item B from culture 2, making the assumption that these items fit into identical structures of relationships. Symbols attain meaning through their relation to other symbols and in the context of a larger symbolic order.

Good, drawing on Barth (1987) goes on to explain how practice, in this example in the form of ritual activity, is involved in establishing the relationship of the

individual to the larger symbolic order of the culture. He argues that a system of medical knowledge and the practices through which it is reproduced, elaborated, and applied are interrelated in complex ways that go beyond those suggested by belief and behavior models, using the example of ritual activity, such as male initiation rites in New Guinea. He contends that such ritual activity involves a transformation of a group of young persons into “men who think and feel about, who sense, nature and themselves in certain ways and with certain imagery” (Barth, 1987, p.79). In other words, ritual activity transforms the ways in which people apprehend themselves, external reality and the relation between external reality and themselves. From this perspective, adequate translation between cultures depends on understanding not only symbolic forms, but the formative practices with which they are associated in hopes of comprehending the modes of experience they mediate. As Kleinman states, “Culture...provides a symbolic bridge between intersubjective meanings and the human body.” (Good, 1994, p. 53.). It is important to try to grasp the forms of intersubjective experience which are unique to the culture and which provide insight into how social and symbolic forms provide members of a society access to distinctive modes of experience. Such an understanding of the ways in which symbolic forms mediate the sensate or sensuous can help the researcher in investigating the ways in which “culture is constitutive of experience” culture is constitutive of experience” (M. J. Good, et al., 1994, p.9).

For example, medical knowledge and its practices serve simultaneously as a theory of the human body and as a basis for reflection on and reproduction of social relations (Lock, 1999). Symbolic structures and oppositions also reflect the more

fundamental structures of society and social relations and render them legitimate, reproducing relations of power and inequality (Lock, 1999). For example, the opposition of male to female corresponds, in many cultures, to other oppositions which index superiority and inferiority such as right/left, hot/cold, pure/impure, culture/nature, mind /body and cognition/emotion. Such everyday ways of sensing relationships in the world serve to reproduce the gender hierarchy and legitimize everyday practices which maintain that hierarchy. The power/shame complex is one distinctive system, found in many cultures, in which power, sex, and the sacred are interrelated. In contemporary Western culture, these oppositions are frequently viewed as being rooted in the verities of biology.

Margaret Lock (1999) takes the position that dealing with actual practices in local sites rather than theoretical abstractions, allows the investigator to examine how people's subjective experiences of themselves are mediated by studying the lived realities of the people who are involved in these practices in specific places. Lindenbaum and Lock (1993) emphasize that forms of knowledge and practices, such as those found in biomedicine and psychology are culturally and historically produced. Lindenbaum and Lock maintain that it is necessary to use an approach which acknowledges this cultural and historical production, an approach which demands dealing with actual practices occurring in local sites, rather than dealing with theoretical abstractions. Such an approach allows the researcher to both address the way in which competing knowledge claims in local sites affect the lived realities of the people who are involved in these practices, and how a person's subjective experiences of self and body are culturally mediated. Such research

may have the added advantage of causing us to begin to de-center some of the categories we use in our own culture to construct experience, such as the deeply interiorized individual “self” of twentieth century Western European society, which is only one of many possible local constructions of self, historically and culturally produced.

An example from my own Second Year Paper (Steinmayer, 2001) illustrates this idea of competing knowledge claims in local sites. One male research participant, who comes from a South American country where the culture of the United States has had a great influence, described an incident which took place when his uncle visited. His uncle had moved to and was living in the United States. The participants explained that this “American” uncle took his sister and himself to a local pool to swim. Once there, his uncle pushed both his sister and him to improve their diving skills. This research participant made it clear that he greatly admired this uncle and, thus, was eager to live up to his expectations, even though the “American” uncle demanded a great deal from the participant in terms of improved performance.

When his sister’s turn came, the participant explained that the uncle also pushed his sister very hard. However, eventually his sister’s diving lesson ended and the participant and his uncle went to the refreshment stand to buy snacks. As they were returning from the refreshment stand, they became aware of a disturbance. They noticed a large cluster of people gathered around something on the lawn. When they got closer, they realized that the people were clustered around

his sister, who was lying on her beach blanket having what appeared to be some sort of “attack” or “fit”, as he termed it.

They consulted a Western doctor, who diagnosed this “attack” as epilepsy, a Western biomedical diagnosis, and gave his sister medication appropriate to this diagnosis. The “attack” was later described to the male research participant and people outside the family as “epilepsy”. However, within the family and, especially, to the participant’s sister, the biomedical term “epilepsy” was not used. The episode was described within the family and to the sister as an attack of “nerves” a culturally defined, locally recognized syndrome, or idiom, of distress. “Nerves” has been described as a category indigenous to local culture which provides a socially acceptable designation for a disorder which does not produce blame (Low, 1989). This sort of disorder has been identified especially frequently among women. Low (1989) has described a prevalence of “nerves” among women in Guatemala and Lock and Wakewich-Dunk (1990) have described a similar syndrome among Greek immigrant women in Montreal.

THE THREE RESEARCH QUESTIONS

To sum up, I was first attracted to the study of gender differences in the construction of pain because work with people with chronic illnesses and substance abuse problems, in particular, led me to become interested in investigating a model of human health and illness which could take psychological, social and cultural factors into account. Models of human health, such as the biomedical model, which adhere to a rigid bifurcation between body and mind did not seem to offer

explanations which could help people suffering from these disorders. An investigation of gender differences in the construction of pain seemed to offer a uniquely appropriate “portal” through which to enter into such an investigation. Fairly consistent gender differences in the perception of and tolerance for pain have been found in laboratory based research. However, the biomedical model has not been entirely successful in accounting for nor dealing with pain. Too often, people’s pain cannot be successfully treated and patients with pain who cannot be helped are regarded as “problem patients”.

The study’s first goal is to investigate the part psychological, social and cultural factors play in the ways women and men construct their experiences of pain. The second, related, aim of the study is to contribute to the understanding and development of a biopsychosocio-cultural model of human health and illness. Should it prove to be the case that women draw on different sets of experiences and different discourses in constructing their experiences of pain than do men, this might provide vital information to health care professionals.

As this review has attempted to demonstrate, differences between women and men in physiological functioning in the domain of pain, as well as in regard to other physiological processes and disorders, might be related to their different experiences during socialization and acculturation. This research attempts to explore how the human experience of pain is intersubjectively constructed through practices and discourses which occur in real places in the physical world. The study investigates the how the discourses and practices experienced by women and men in the course of everyday life differ and are similar. It explores how both differences

and similarities in the way women and men construct their experiences of pain in everyday life affect the ways in which women and men deal with their experiences of pain.

To investigate this, the study draws on theory in narrative and life story construction and on the concept of structuration, drawn from geography, to help to investigate these similarities and differences and how they arise. I will investigate the places in which women and men say they have experienced pain and the discourses and behaviors which they describe themselves witnessing, engaging in and having directed toward them in order to answer the following three

RESEARCH QUESTIONS:

Research Question 1:

In what ways are men's and women's " constructions" of pain similar and different?

Research Question 2:

In what types of spaces and places do men and women have experiences of pain?

Sub-question: With what people, if any, do they interact in these spaces and places?

Research Question 3:

What do men and women do to deal with pain?

Sub-question: How are men's and women's constructions of pain related to what men and women do to deal with pain ?

Chapter Two

METHODOLOGY

RESEARCH DESIGN

Multiple methods were used in this research for three major reasons. First, multiple methods were employed to make the research as thorough as possible. The data obtained using several methods helped in understanding the real, multi-faceted, lived experiences of the research participants, which was a major emphasis in this study of the ways female and male participants construct their experiences of pain in everyday life. Second, the use of multiple methods made the research more responsive to the participants concerns. This helped to illuminate previously unexamined issues regarding gender differences in perceptions of and tolerance for pain. Finally, the use of multiple methods in a single study, often referred to as “triangulation”, when it results in congruent data, offers support for the validity of the data obtained.

Four methods were used. First, the “Pain Narratives Protocol” was employed, a method based on narrative theory and especially designed for this study, in which participants were asked to write narratives about two of their experiences of pain in everyday life. The second method, called the “Map Drawing Protocol”, is also a method developed by the researcher for this research project. This component of the research was especially designed to help participants use the visuo-spatially oriented process of drawing to focus on the physical settings in which experiences of pain occurred during two specific periods in their lives. This was followed by the third

method used in the study, the “semi-structured Life Story Interview”, which was developed based on the “life story” literature. This is an open-ended interview with probes used to investigate the participants’ ways of dealing with pain in everyday life. Finally, participants were asked to complete a standardized questionnaire dealing with ways people cope, called the Coping Styles Questionnaire (CSQ).

A section containing additional questions was included at the beginning of the Interview Protocol to obtain information on demographics. In addition, a brief closing section was included toward the end of the interview to allow the participants to furnish any additional information, to discuss their expectations of and experience in doing the interview and to provide closure.

DETAILED DESCRIPTION OF THE FOUR METHODS

In the Pain Narratives Protocol, participants were asked to think about any personal experiences of pain that they have had at any time in their lives. The researcher recorded these experiences in a list (see Appendix A). When participants said that they could not think of any other experiences of pain, they were asked to select one of these self-generated experiences of pain from the list and to take about ten to fifteen minutes to write about it. Participants were then asked to select one other experience from the list and to take another ten to fifteen minutes to write about this second experience of pain.

Following the writing of the two narratives, the participant was interviewed about each of the narratives she or he wrote. This “post- narrative” part of the Pain Narratives Protocol is constructed in the form of an open-ended interview with

probes and is designed to ensure that the researcher can read the narrative, understands what the writer is saying in the narrative, and begins to get an idea of the “voices” and actions of actual people in past interactions which have affected the participant’s construction of his or her experiences of pain.

The Pain Narratives Protocol was developed and revised during extensive pre-testing with eight people. In addition, a version of this method was used by the researcher in a previous study for her Master’s Thesis work (Steinmayer, 2001). In that project, participants simply were asked to take about ten to fifteen minutes to write about first one and then a second experience in their lives. During pre-testing, three major revisions were made to the protocol used in the Master’s Thesis work. First, it seemed necessary to provide more of an introduction to this part of the interview, since it is not a task with which people are familiar. It also appeared to be necessary to break the interview instructions into two steps, first to ask participants to think of experiences of pain in everyday life and then to ask them to write about them. In the first step of this revised procedure, participants were asked to tell the researcher about any experiences of pain they had experienced. The researcher made a list of these experiences as participants mentioned them. Then, as a second step, participants were asked to pick first one and then a second experience from this list to write about. This procedure seemed to help participants think of their experiences of pain in everyday life. It also appeared to help create a smoother transition to writing about them.

During pre-testing, a third change to the earlier protocol was made. An open-ended interview with probes was developed to follow the writing of the two

narratives. The original idea for the narrative analysis was based on Bakhtin's (1986; 1981) conception of the "voices" of past interactions remaining present in people's current utterances and sprang from the researcher's participation in an earlier research project on children's moral development. One striking aspect of these interviews was the children's use of expressions such as "If you tell a lie, the nose grows" (Steinmayer and Millery, 1999). In particular, the words the younger children in the study used often seemed to consist of an almost verbatim repetition of phrases they had probably heard from adults in their environments during social situations such as talking at the dinner table. However, during pre-testing of the Pain Narratives Protocol with adults, it proved difficult to discern such clearly derived, verbatim wordings. This made it necessary to develop the open-ended interview with probes which follows the writing of the two narratives.

After writing Narratives of two experiences of pain and being interviewed regarding these Narratives, the "Map Drawing Protocol" is designed to extend this discussion of the participant's life experiences involving pain. This part of the interview is constructed especially so that participants use the visuo-spatially oriented process of drawing to help them focus on the actual physical settings in which experiences of pain occurred in their lives. The goal of this component of the research is to obtain the richest and most detailed information possible regarding the places where participants had interactions involving pain, the nature of these interactions, including both conversations and activities, and the people involved in these interactions.

Like the Pain Narratives Protocol, the Map Drawing Protocol was based on a similar procedure developed for and used in the researcher's Master's Thesis (Steinmayer, 2001). In addition, the Map Drawing Protocol was pre-tested on a small sample of two people. The questions accompanying the Map Drawing which were used in the protocol of the earlier study were adjusted to include probes which were developed based on the literatures on social support and coping. In the resulting probes, participants are asked about the nature and structure of the environment, what took place in each environment, who, if anyone, was present and who was deliberately excluded, what types of interactions occurred, who was involved in these interactions and what each person present did or did not do and/or say. The redesigned protocol was pre-tested on only two people because few alterations were required.

In the Map Drawing Protocol (see Appendix A), participants were asked to select two experiences of pain, one from each of two pre-set age ranges. First, participants were asked to think of an experience of pain which occurred in childhood, defined for the purposes of this study as between the ages of six through eleven. Participants were asked to draw the setting in which this experience of pain occurred and to explain their drawings, either as they drew or after completing their Drawing, whichever was more comfortable for the participant. Next, each participant was asked to think of an experience of pain which occurred in adolescence, defined as between the ages of twelve through seventeen, and, again, draw and explain the setting. Each participant was asked to make a total of two separate drawings, one

for each of the age ranges specified, depicting the settings in which two experiences of pain occurred.

As in the Narratives Protocol, the open ended interview with probes following the Map Drawing Protocol is designed to ensure that the researcher understands each environment the participant depicts, including the nature and structure of the environment itself, what took place in each environment, who, if anyone, was present or excluded, what types of interactions occurred, who was involved in these interactions and what each person present did or did not do and/or say. Participants were asked to identify the people with whom they spoke and interacted and to recall, to the best of their abilities, the content and nature of these interactions and communications. The probes were used to ask about any issues which participants did not address themselves and to clarify the researcher's understanding of what participants said. Finally, the last few probes in the Map Drawing Protocol ask participants to think about both what they wrote in each of their two narratives and what they have drawn, and to reflect on whether they see any connections or patterns.

The rationale for selecting experiences of pain in this manner for discussion in the Narrative and Map Drawing Protocols is that these procedures allow the researcher to discuss four different experiences of pain with each participant, two in the Narratives Protocol and two in the Map Drawing Protocol. The experiences which each participant chose to write about in the Narratives, and, subsequently, discuss, were entirely self-selected and could occur at any time in the life of each participant. However, each of the two experiences asked for in the Map Drawing

portion of the interview must have occurred during the two pre-set times in the participant's life. This procedure ensures that information will be obtained about two similar periods in the life span for all participants.

In addition, the Map Drawing portion of the interview is designed to further focus the attention of the participant on specific interactions which took place during two periods of the participant's growing-up years. This was planned to help the participant discuss the actual practices and "voices" which she or he encountered in real interactions in the world and began to talk about in the Narratives section of the interview. This is intended to assist the researcher and participant in investigating the actual practices and "voices" which are part of each participant's experience and may have contributed to his or her customary manner of constructing his or her experiences of pain.

The fourth section of the research, the semi-structured Life Story Interview (see Appendix A), is an open-ended interview with probes which inquires about the participant's ways of dealing with pain in everyday life. It begins with a large, open-ended question asking participants to reflect on experiences of pain they have had throughout their lives. Participants were asked to try to draw on the previous discussions of four specific experiences to help the researcher "understand more about how pain has figured in your life in general". At this point in the interview, those participants who had not mentioned any experiences of pain occurring in adulthood were asked about experiences of pain in adulthood. In the open-ended question following this, the researcher also asked if there are any major experiences of pain, occurring at any time in the participant's life, which the participant has not

mentioned. It is important to keep in mind that, before beginning the interview, all participants have been told that they have the right to refuse to answer any question and to stop the interview at any point. Thus, if a participant does not want to divulge any of this information or if any of these questions make a participant uncomfortable, the participant knows she or he has the right to refuse to address the question.

In this section of the interview, participants are also asked to talk about the people they can rely on for help, whether they have been able to find names to identify any painful conditions, experiences with health care personnel, ways in which experiences of pain have affected key areas of their lives, such as personal relations, work, leisure activities and major life events, and the relationship between pain experiences and their views of self. The objective of this section of the interview is to encourage participants to identify and summarize major issues and themes of which they themselves have become aware during this interview on their experiences of pain.

The Life Story Interview is followed by the closing section of the open-ended interview (see Appendix A), which is designed to allow the participant to furnish any additional information she or he feels is important and which has not yet been covered in the interview. In this section of the interview, participants were given the opportunity to expand on any issues they talked about previously. In addition, participants were asked to tell the researcher about their expectations of this interview about experiences of pain in everyday life and about their experience in doing the interview. This question was designed to provide closure for participants at the end of a long, open-ended interview during which they have been asked to

think about and discuss a deeply personal subject which is not usually discussed in our culture.

Finally, each participant was asked to complete the Coping Styles Questionnaire (CSQ), (See Appendix B), a frequently used, standardized questionnaire concerning ways people cope with pain. This questionnaire asks the research participant to identify characteristic ways in which he or she copes with pain in daily life. However, since no context is asked for nor provided, this is a decontextualized instrument. It is possible that people cope differently with experiences of pain depending on environmental and contextual factors such as whether they are alone or in the company of others, whether they perceive a definable precipitating event, perceived controllability of the pain given the overall situation, perceived probable duration of the pain, and the time of day when this event occurs. For example, if a painful experience occurs in the early morning hours, when one is likely to be alone, when many activities are constrained and when it is often more difficult to obtain assistance, these factors may affect one's experience of the pain and the ways in which one copes with it.

This questionnaire, designed for use with large samples, was included in this study in order to compare the ways of coping endorsed on this standardized measure of ways of coping with the ways in which participants depicted themselves coping in their spontaneous, contextualized constructions of their experiences of pain in daily life. Since the total number of participants in this study was small, a total N of nineteen, only the most elementary, descriptive statistics could be calculated. The CSQ consists of statements of holistic behaviors, such as "I count

numbers in my head or run a song through my mind” and “ I try to be around other people”. Endorsements of the CSQ statements are grouped into seven categories, including Diverting Attention, Reinterpreting Pain Sensations, Coping Self Statements, Ignoring Sensations, Praying/Hoping, Catastrophizing and Increasing Behavioral Activities. This coping instrument is short and required limited time and effort on the part of participants.

CONDUCTING THE INTERVIEW

Two Minor Revisions Were Made to the Overall Interview During the Course of the First Three Interviews.

Two relatively minor revisions were made to the interview during the course of the first three interviews. First, after the first interview, it was apparent that the single question “What is your ethnicity?” followed, for clarification, by the alternative wording “What do you identify as your ethnicity?” could be confounded with the question of the participant’s religion. For example, the first participant said she thought she was Jewish, but that she also thought of herself as Semitic. In addition, it seemed important to obtain information about each participant’s religion because it might play a role in the way the participant constructs her or his experiences of pain. In order to deal with this, an additional, separate question was added asking “ What is your religion?”. It was important to obtain clear information on both these issues because a basic theoretical premise of this study is that culture influences the construction of the physical body in humans, and both these questions are aimed at finding out about how participants self-identify culturally.

The second revision addressed a major conceptual issue, although it necessitated only a minor change in wording. Conceptually, the fourth part of the interview, the semi-structured Life Story Interview, needed to be constructed in such a way that it helped participants move beyond the specific instances of pain in everyday life, discussed in the Narratives and Map Drawing Protocols, to a broader discussion of the participant's experiences of pain in life, generally. In addition, if the participant had not yet mentioned any experiences of pain in adulthood, this needed to be investigated. In order to make a clearer transition from the individual narratives presented in the Narratives Protocol and contextualized stories produced in the Map Drawing Protocol to overall life experience, the large, open-ended question with which the semi-structured Life Story Interview begins was re-worded slightly.

In addition, a second part of this beginning open-ended question was created, which read, "Are there any major experiences of pain which you haven't mentioned?" This question was followed by a reminder that the participant had the right to refuse to answer any questions or to stop the interview at any time in case this question induced discomfort. However, in all interviews, the participants seemed to be very engaged by this point in the interview and all participants were quite willing to become engaged in a discussion of this.

Participants Seemed to Become Engaged in the Interview

One of the most important indications that the design of the interview was appropriate, was that the interview structure seemed to "work" for the participants.

The interview protocol appeared to provide a format in which they could describe their life experiences in a way that “flowed”, rather than having to pull their experiences apart to fit the interview questions. The literature on life story interviewing illuminates why this is significant. Two major issues on which the life story literature focuses are agency and engagement. Specifically, the life story literature suggests that the researcher pay attention to how engaged in the interview the participants appear to be. During the construction of the semi- structured Life Story Interview, both these issues, engagement and agency, were sources of concern. It seemed that some of the questions might be somewhat awkward to answer, especially because participants were being asked to talk to a stranger about experiences not usually discussed during normal, everyday conversations in our culture. As some research participants put it, “We really don’t talk about pain very much in everyday conversations” and “This is not just your everyday topic”. This raised concerns about whether participants would be able to become engaged in the interview and about how much the participants themselves, as agents, would be able to shape their answers to explain their own experiences. However, participants seemed to be able to relate to the interview questions quite well. For example, after completing the interview, several participants said that they had found the interview very interesting to do. Some participants said that they thought they had learned something about themselves and the ways they deal with pain. Some participants said that they thought they had gained insight into their ways of handling pain.

The literature on life story interviews also emphasizes the importance of observing whether anything “breaks down” during the interview, and if so, when. In addition, the literature on life story interviewing explains the importance of observing whether, and when, anyone, participant or interviewer, becomes uncomfortable during the interview. While a few participants displayed some slight discomfort at times in the beginning sections of the interview, and, especially, during the second part of the Map Drawing Protocol, they all seemed not only to be very engaged in the interview process, but also to become increasingly engaged as the interview progressed. The interactions during these interviews were usually like easy, comfortable conversations between friends. What the participants and the interviewer were saying just seemed to “flow together” smoothly. Participants’ feelings that the interview provided a structure, or situation, which allowed them to talk about pain as though it were an “everyday” topic of conversation addressed an important methodological concern in this study of women’s and men’s experiences of “everyday” pain, that participants feel sufficiently comfortable with the questions and engaged in the interview so that their constructions would reflect their real, lived experience as much as possible.

PLAN FOR ANALYSES

The following procedures were employed to analyze the data. The procedures are presented in the order in which they were used, beginning with the analysis used first. The description of each analytic procedure includes an

explanation of the procedure, the parts of the overall interview included in the analysis and the research question or questions addressed by the analysis.

First: Overall Content Analysis

An overall content analysis of five components of the interview was conducted first to provide an initial, data driven overview of what the participants said and of the major themes which emerged across methods. This analysis included five parts of the overall interview: the introductory section asking for demographic information, the Narratives Protocol, the Map Drawing Protocol, the Life Story Interview, and the closing section of large, open-ended questions. It was used to address all three Research Questions, including: Research Question 1: “In what ways are men’s and women’s “constructions” of pain similar and different?”, Research Question 2: “In what types of spaces and places do men and women have experiences of pain?”, the subquestion to Research Question 2: “With what people, if any, do they interact in these spaces and places?”, Research Question 3: “What do men and women do to deal with pain?” and the subquestion to Research Question 3: “How are men’s and women’s constructions of pain related to what men and women do to deal with pain?”

Second: In Depth Analysis of the Ways Five Participants Described Dealing with their Experiences of Pain in the Context of their Overall Life Stories

This analysis was conducted in order to investigate the ways in which five participants, including three women and two men, constructed their experiences of

pain in their lives over the course of their individual interviews. The five interviews were selected to investigate and clarify issues which were uncovered in the content analysis. This in-depth analysis drew on the life story literature and included five sections of the overall interview: the beginning section asking for demographic information, the Narratives Protocol, the Map Drawing Protocol, the Life Story Interview and the closing section of open-ended questions. It was used to address all three Research Questions, including: Research Question 1: “In what ways are men’s and women’s “constructions” of pain similar and different? Research Question 2:” In what types of spaces and places do men and women have experiences of pain?”, the subquestion to Research Question 2: “With what people, if any, do they interact in these spaces and places?”, Research Question 3: “What do men and women do to deal with pain?” and the subquestion to Research Question 3: “How are men’s and women’s constructions of pain related to what men and women do to deal with pain?” The analysis also addresses the additional research question which arose in the early phases of this analysis, which was “How do women and men integrate their experiences of pain into their overall stories of their lives?”

In this analysis it was important to help the reader fully understand how these five participants portrayed their experiences of pain over the course of their interviews. This analysis dealt not only with the major themes about which these five participants spoke, but also how their descriptions of their experiences unfolded over the course of the interview and the emotions they expressed while discussing these experiences. In order to accomplish this, each description begins with a brief

“re-introduction” of the participant, in the form of a quick review of relevant personal information and demographic data provided by the participant over the course of the interview. Next, the “tone” and overall experience of the participant’s interview are described, including any major shifts in emotion and where these occurred. Next, the “shape” which emerged in the interview is explained, including the overall structure or organization of the participant’s interview. Finally, the content of the participant’s comments on her or his experiences of pain in life is examined. Major themes are presented and illustrated with direct quotes and examples recounted by the participant.

Third: Five Specific, Detailed Analyses of the Two Written Narratives

Three analyses of the words used by each participant in their two written Narratives were conducted in order to address Research Question 1: “In what ways are men’s and women’s constructions of pain similar and different?”. First, a count was made of the total number of words used by women and men in each of their two written Narratives. Next, the average number of words across both Narratives was calculated for each participant. Finally, the average number of words for each group, women and men, was calculated. These counts were performed because, in pilot data, women’s narratives of painful experiences appeared to be much longer, containing a greater number of words, than men’s. It is possible that men are less inclined to talk at length on any topic and that talking about pain is especially uncomfortable for men. On the other hand, verbal communication may present a principle form of release and way of coping with pain for women. The number of

words in men's and women's Narratives may furnish an important piece of evidence regarding this issue.

Second, the adjectives spontaneously used by women and men, respectively, in their two written Narratives were recorded and compared. The goal of this analysis was to investigate the similarities and differences between women and men in the types of adjectives they employ in their written, narrative descriptions of painful experiences occurring in daily life. This analysis was based on the results of prior research using the Multidimensional Affect and Pain Questionnaire, a standardized scale considered to be a highly effective instrument in pain research. In this research, men appeared to be more likely to use adjectives which describe the physical aspects of pain, such as "throbbing", "sharp" and "dull", while women were more likely to use adjectives which describe the experience of having the pain, such as "I feel sad" or "I feel unfortunate."

Third, a further analysis of the types of words used by women and men, respectively, was conducted, drawing on the research of Pennebaker (1997) and Keough (1999) on narratives written about experiences of trauma and illness. Pennebaker and Keough identified three elements in these narratives which seemed to predict positive effects on health due to narrative writing: 1) more frequent use of positive emotion words, 2) a moderate number of negative emotion words, and 3) an increase in both causal and insight words, characterized by these authors as "cognitive" words, over the course of writing. Pennebaker and his colleagues identified this last category of words, causal and insight words, as the "most important" predictor of positive effects on health due to narrative writing. Moreover,

such an increase in causal and insight words was found to covary with the judges' assessment of the coherence of the narrative.

For the analysis used in the current study, a count was made, for each Narrative, of the number of positive emotion words, the number of negative emotion words and the number of words dealing with causation and/or insight. Based on these counts, the ratio of positive emotion words to negative emotion words for each Narrative was computed. Composite ratio scores for each participant across the two Narratives and for men and women in general were then computed. Lists of the sorts of words frequently used by each group were also compiled.

A fourth analysis of the participants' two written Narratives was conducted to address Research Question 1: "In what ways are men's and women's "constructions" of pain similar and different?", as well as Research Question 3: "What do men and women do to deal with pain?", and the sub-question to Research Question 3: "How are men's and women's constructions of pain related to what men and women do to deal with pain?". This analysis was based on Leventhal et al.'s (1987, 1985, 1984, 1980) well known work on the ways in which people represent health and illness. They identified the following five components of research participants' representations: 1) Label, 2) Cause, 3) Duration, 4) Course, and 5) Curability. The analysis used in the present study drew on the work of Leventhal and his colleagues to identify and describe the ways in which men and women were similar and different in regard to what they said about and how they used each of these categories in talking about their experiences of pain.

Finally, the fifth analytic strategy used to specifically address participants' two written Narratives helped to answer Research Question #1: "In what ways are men's and women's "constructions" of pain similar and different?", the sub-question to Research Question 3: "How are men's and women's constructions of pain related to what men and women do to deal with pain?", and the sub-question to Research Question 3: "What do men and women do to deal with pain?". This analysis was based on Kenneth and Mary Gergen's (1988) attempt to distill the critical ingredients for forming a narrative which is regarded as a viable narrative in our culture. These ingredients would also delineate the rules for constructing one's personal past, since the Gergens think that constructing memories of oneself involves engaging in a public ritual of construction, not a retreat into the individual's personal, isolated mental processes. The critical ingredients they identified include: **1) A valued endpoint**, which is often a point with established value within the culture, specifying the story's direction and implying where it should terminate. **2) The selection of related events**. Once the endpoint has been established, this will largely determine what subsequent contents will be appropriate. **3) A temporal ordering of events**, which may be internally dictated, as in the works of Proust or Joyce, or recounted in terms of linear clock time as though a movie camera were placed before the self. **4) Causal linkages**, which given that causality does not really exist objectively in nature so that one cannot directly observe causality, demand an **interpretive commitment**. This amounts to a textual or rhetorical device for generating acceptable accounts of relationship between events which are isolated. **5) Demarcation signs** which are necessary to demarcate memories of the self within

the story. Demarcation signs, thus, operate to indicate when accounts serve as reports on self memory. The elements the Gergens have identified as critical ingredients for a narrative in our culture will serve as analytic tools in analyzing both Narratives written by female and male participants.

A special worksheet was constructed to record information on all five specific analyses of the two written Narratives. A sample worksheet is included (see Appendix C).

Fourth: Analysis of the Map Drawings

Both the Drawings themselves and the accompanying information supplied by participants either spontaneously or in answer to probes on the open-ended interview were analyzed to answer Research Question 2: "In what types of spaces and places do men and women have experiences of pain?" the subquestion to Question 2: "With what people, if any, do they interact in these spaces and places?", and Research Question 3: "What do men and women do to deal with pain?" and the subquestion to Research Question 3: "How are men's and women's constructions of pain related to what men and women do to deal with pain?"

This analysis was based on the concept of Structuration, a geographical concept which specifies that people do not conduct activities in the environment at random, but, rather, that certain activities are conducted in specific places in structured ways. In this analysis, the focus was on the places where male and female participants described having experiences of pain. It included information participants provided concerning the places where the two experiences of pain they

chose to depict occurred and what these places were like, the people who were present in these places, who these people were, what their relation to the participant was, what they did and did not do, and what they said, to the participant and to each other. It encompassed information participants provided regarding situations in which they engaged in discourse with others and in which they saw behaviors which influenced the ways in which they learned to deal with pain.

Fifth: Analysis of the CSQ, the Standardized Scale

For this analysis, each participant's responses to the standardized CSQ were computed. This analysis was used to address Research Question 3: 'What do men and women do to deal with pain?' Following the instructions provided with the scale, participants' endorsements of statements regarding how they cope with pain were grouped into one of seven dimensions, including: Diverting Attention, Reinterpreting Pain Sensations, Coping Self Statements, Ignoring Sensations, Praying/Hoping, Catastrophizing, and Increasing Behavioral Activities. Scores for each participant on each dimensions were recorded in a table (see Table 4). Participant's endorsement of items on the CSQ were also compared to the ways in which they described themselves dealing with painful experiences in daily life in other sections of the overall interview (see Table 5).

RESEARCH PARTICIPANTS AND RECRUITMENT

Qualifying Characteristics of the Research Participants

The nineteen research participants were aged eighteen to fifty. The lower limit of this age range was selected to ensure that all participants would be able to address the full range of experiences asked about in the interview, especially in the second part of the Map Drawing Protocol, in which participants are asked to think of an experience of pain which occurred when they were aged twelve through seventeen. The upper limit of fifty for the age range was selected because previous work on gender differences in regard to perception of and tolerance for pain, conducted by biopsychologists, indicated that women's perceptions and tolerance of pain varies across the menstrual cycle (Goolkasian, 1980). These variations across the menstrual cycle were interpreted as indications that hormonal factors play a role in women's experiences of pain, suggesting that women's perceptions of pain may change at menopause. In addition, while it is possible that differences between the genders persist after the age when most women experience menopause, the nature of these gender differences in pain perception and tolerance may change after menopause. It is possible that there are distinctive gender differences in perception of and tolerance for pain in different age ranges. For both these reasons, it was decided to limit the age range of participants to between eighteen and fifty.

The initial sample consisted of thirteen participants, ten women and four men. These participants responded either to word of mouth information or to an e-mail sent out through an academic e-mail list. Preliminary analyses indicated that this initial group of participants was extremely ethnically diverse. Several participants were born and raised outside the U. S. The original thirteen participants also had an

unusually high level of education. It seemed desirable to have a more nearly equal number of men to women. It also seemed important to explore differences between people born and raised in the U.S. and those born abroad suggested by the responses of the initial group of participants and to try to recruit participants with less education. Using a grounded theory recruitment strategy, six additional participants were recruited. A particular effort was made to include at least three additional men. The accompanying table (See Tables 1 and 2) presents data regarding basic demographic characteristics of the nineteen research participants in the final sample.

Recruitment

The initial plan for recruitment was to recruit participants through e-mail, through word of mouth and through posters, put up, with permission, in locations throughout the city. Additional participants were to be recruited through a networking or snowballing procedure in which, on completion of the interview, participants would be asked if they knew anyone they thought might be interested in participating in the study. Participants would be told that these people could be friends, acquaintances, or friends of acquaintances. As an additional incentive, because of time constraints on completion of the research, participants were offered twenty dollars for participating in the research.

Based on the advice of the group of collaborating biopsychologists, who were working on a pain study at the New York State Psychiatric Institute, the subject of pain was not to be mentioned in any announcements of the study. These

experienced pain researchers cautioned the researcher that the mention of the topic of pain was likely to attract people for whom pain was a major issue. It was important that participants in the study should not be people for whom pain posed a special issue. Since the objective of the study was to examine non-clinical experiences of pain occurring in the course of daily life, these people would not be appropriate

Consistent with this plan, in midsummer of 2003, people were made aware of the research project through word of mouth. In addition, the researcher obtained permission to send an announcement of the research through an academic e-mail list. In both word of mouth and e-mail communications, information was provided on the general nature of the research, but the topic of pain was not mentioned. Participants were simply told that this was a study of “everyday life experience”. Information was provided on how people interested in participating in the study could contact the researcher (see Appendix D, for the e-mail text). When potential participants contacted the researcher, they were screened during a brief telephone conversation in order to avoid recruiting participants with clinically significant or chronic pain. A special Screener Form (see Appendix E) was developed for this study in order to make every effort to avoid recruiting people for whom the subject of pain was a special issue. If the potential participant did not report having clinically significant or chronic pain, an appointment was made for the interview.

At least three participants specifically mentioned becoming aware of the research through information disseminated by word of mouth. In addition, within a week of its posting, there were over thirty responses to the e-mail sent out through

the academic e-mail list . This large response may have been due to the time of year, midsummer, when many students and others involved in academia have spare time. When they appeared for the interview, several participants said that they knew that the study was being conducted for a doctoral dissertation. Due to their own experiences in trying to complete academic work, their main motivation was a desire to help a fellow student. Based on the statements of the participants during the interview, the offer of twenty dollars seemed to have had little or no effect on most participants' decisions to participate in the research. In fact, several participants said they were very surprised when they were offered twenty dollars upon completion of the interview, even though this had been mentioned in both the word of mouth and e-mail communications, during the brief screening interview conducted over the phone and in the Consent Form, which all participants read before proceeding with the interview. Beyond this, several participants refused to take the payment of twenty dollars when it was offered to them at the end of the interview. In these cases, participants were told that this remuneration was part of the research budget, so there was nothing else that could be done with it. The researcher suggested that these participants might want to donate the twenty dollars to a favorite charity or cause.

Because of this large initial response to the word of mouth and e-mail announcements, the researcher did not put up the planned posters while recruiting the thirteen participants in the initial sample. The additional six participants were recruited using remaining volunteers from the original e-mail responses and through additional networking and word of mouth.

Chapter Three

THE RESEARCH PARTICIPANTS

INTRODUCTION TO THE CHAPTER

The main objective of this chapter is to provide the reader with a comprehensive view of the research participants. The chapter begins with a brief description of my experience working with the nineteen participants. Next, the participants are described in terms of the demographic information they provided at the beginning of the interview.

THE FIRST VIEW: THE EXPERIENCE OF WORKING WITH THESE NINETEEN PARTICIPANTS

My experience working with the nineteen people who participated in this research project was highly collaborative. Due to the exploratory nature of this project, neither I, as the researcher, nor the people who were kind enough to participate in the research, knew just what we would discover. This seemed to create an atmosphere of mutual exploration and collaboration during the interviews. The individuals who took part in this study were all willing to become very actively involved and engaged in the research project. They were very much active “participants”, not passive “subjects”. I was amazed at the wide range and deep articulation of the experiences which they shared with me. Because of their whole-hearted participation, you, as the reader, will be hearing in-depth about some of their

most intimate life experiences of pain. I hope, and, based on their comments, I think the research participants also hope, that their accounts of their experiences will help in achieving a better understanding of the human experience of pain.

My experience of working with the nineteen participants in this research was, also, one of working one-on-one with nineteen highly individual people. In the course of exploring with them their own, lived experiences of pain, I was deeply impressed by how unique and special each individual's experience was. Due to both the collaborative nature of each participant's involvement in this project and their unique characteristics as individuals, conducting the interviews for this project was a fascinating experience. I think readers will acquire a better sense of the participants as individuals if I explain that the research participants selected their own, often uncommon and quite expressive, names. At the end of the interview, each participant was asked to choose a name which I could use when writing the research report. The names selected by the research participants were used in all but two cases in which they coincided with the real names of participants who became involved in the study later. To ensure confidentiality, I selected new names for these two participants, although I did my best to choose names which adhered closely to the character of the names they themselves had selected. All the other names were chosen by the participants themselves. Participants also specified how they wanted the names they selected spelled. All the participants appeared to be surprised and pleased at being given the opportunity to select their own names.

THE SECOND VIEW: AN OVERVIEW OF THE RESEARCH PARTICIPANTS

A total of nineteen people participated in this research study, eleven women and eight men (see Tables 1 and 2). The women's ages ranged from twenty-four to forty-eight. The men's ages ranged from twenty-five to forty-one. The mean age of the women, 32.2 years, was slightly lower than that of the men, which was 33.5 years. Eleven of the participants were single. Of the eight men interviewed, three were married (38%) and five were single (63%). However, two of the single male participants had partners. One man lived with his partner while the other did not. Of the eleven women interviewed, five were married (45%) and six were single (54%).

The participants in this research were particularly well educated, with eight of the nineteen participants holding at least a Master's degree (42%). An equal number of female and male participants had completed Bachelor's degrees, five women and five men, although this represented a larger proportion of the male participants, 5/8 (63%) compared to the proportion of female participants 5/11 (45%). Only one male participant, Paris, the thirty -eight year old man from Virginia who identified himself as "Black", had completed less than a Bachelor's degree. However, Paris had completed two years of a four year college curriculum. Surprisingly, a greater proportion of the female participants held a Master's degree or above, 6/11 (55%), while only 2/8 (25%) of the male participants held a Master's degree. The highest level of education had been attained by one female participant who had completed a Doctoral degree.

The information participants provided about other aspects of their lives, including income, occupation and ethnic identity, displayed complexity. For example,

the incomes of many participants depended on more than one breadwinner. Some participants had recently broken up with a partner, whose income no longer made a contribution to the household. Many participants, especially women, held one or more jobs, some while also attending school to obtain advanced degrees.

Participants' incomes covered a broad range. The women's incomes covered an even wider range than did the men's, from less than \$10,000 to over \$100,000, the highest income category provided. However, the woman who reported an income of over \$100,000 explained that this income came solely from her husband's job. She herself had recently lost her job as a research assistant. The men's incomes ranged from less than \$10,000 to between \$61,000 and \$80,000, the second highest income category provided. However, one of the two men who reported a combined household income for the past year of between \$61,000 and \$80,000 explained that this represented the household income while he was living with his girlfriend, who had since moved out. The other man who reported a combined household income of between \$61,000 and \$80,000 said that this amount represented only his income because his wife was in school and was not working.

The wide range in the participants' incomes presaged the wide range of activities participants reported when explaining their occupations. At the time of the interview, two of the female participants were not working: Bertha, who was a full time graduate student, and Anya, who had just lost her job as a research assistant due to budget cuts. Two of the women were doing office work: Archis, from Barbados, had just completed a Bachelor's degree and was doing full time office work for a friend's mother, while Zum, from Turkey, was doing part -time office work

while attending graduate school as a full time student. Zum was one of six female participants who was working part time in some capacity while attending school.

Four female participants were working as research assistants or interviewers while attending graduate school: Olivia, from Colombia, who was working part time as a research interviewer; Sooty, the female participant of East Indian descent who was working part time as a research assistant in a Neuropsychology Lab; Bianca, born and raised in Queens, New York, who was also working as a research assistant.

The fourth woman, Cathy, originally from Hong Kong, was working both as a research assistant doing library research and as a part-time, adjunct professor. One woman, Julie, from Albany, held two part-time jobs, as a mid-wife's assistant and a writing tutor, while taking undergraduate courses in nursing. Georgina, originally from Hungary, was working as an activities coordinator in supportive housing and had just begun graduate school. Finally, Jan, who holds a Doctoral degree and was raised in the New York City area, was working part time as a research professional.

The men's occupations also encompassed a wide range of jobs. Only one male participant was not working at the time of the interview. Kawika, the twenty-nine year old man of Japanese-German descent who had completed a Master's degree, was not able to work because his visa status did not authorize him to work in the USA. Both he and his wife were living on her income. Only two male participants held more than one job while attending graduate school. Sergei, raised in the USSR, was teaching part time and working part time as a technician in a Sleep Laboratory. Finn, born and raised in Amherst, Massachusetts, was working as the co-ordinator of a computer lab at a local college. Finally, Alasdair, the

twenty-five year old man born in New York City, held three part-time jobs, working as a writing tutor, a freelance writer and a “kind of consultant for a composer, dealing with his computer issues”. The other four male participants all held a single job. Paris, the participant who had completed the fewest years of formal education, was just beginning a job as a delivery person for a new Internet food delivery service. Luke, born in Brazil, was working for a municipal agency as a data manager. Bob, the forty-one year old man born and raised in the San Francisco Bay area was working as a computer programmer and analyst. Finally, Jack, the thirty-three year old man from San Francisco, worked as a field events manager for a sausage company, conducting “food demonstrations and showing clients how to show and manage the products”. However, Jack explained that he held an MFA in acting and that he regarded acting as his real profession, although he was not working as an actor at the time.

The information participants provided regarding place and ethnicity also demonstrated intricate patterns of relationship. Although all the participants were living in the New York City area at the time they were interviewed, they came from a wide range of geographical areas. A higher proportion of the older participants were born and raised solely within the United States. Also, a slightly higher proportion of male than female participants were both born and raised entirely within the United States. Overall, five male (63%) and three female (27%) participants were born and raised in the United States. However, two other female participants were born in other countries, but largely raised near big cities on the eastern seaboard of the United States. If they are included with the female participants born and raised

entirely within the United States, there is less of a difference in the proportions of female to male participants born and mostly raised in the United States: 63% of male participants to 45% of female participants, which makes the male and female samples more similar. Six of the eleven female (54%) and three of the eight male (13%) participants were born and raised mostly in places outside the United States.

Only one woman and one man were born in New York City or its immediate environs, Bianca, the thirty year old woman who was born and raised in Queens, New York, and Alasdaire the twenty-five year old man who was born in New York City and raised partly there and partly in New Jersey. One other female participant, Jan, who was forty-eight at the time of the interview, moved to a borough of New York City at the age of two and has lived in the same neighborhood ever since. Three women and five men were born and raised in a variety of other places within the United States, including San Francisco, Virginia, Amherst, Massachusetts and Albany, New York. One female participant, Bertha, was born in Israel and raised partly there and partly in a residential suburb of a city on the Eastern seaboard of the United States. The other twelve participants came from a wide range of geographical areas throughout the world, including Barbados, Turkey, Colombia, Hungary, The Czech Republic, The USSR, Brazil, Japan, Hong Kong, and London, England.

In an open-ended question in the introductory first section of the interview, participants were asked to use their own words to describe their personal perceptions of their ethnic identities. This resulted in an interesting pattern of responses concerning place, ethnicity and identity. Overall, participants who had

been born and raised in the USA seemed to be familiar with, and know how to employ, the categories for ethnicity usually used in the United States. However, even some of these natives of the United States did not seem entirely comfortable with using the standard ethnic classifications. Participants who were not born and raised in the United States displayed even greater discomfort in trying to fit their experiences of their social and cultural roots into the standard categories for ethnicity which all of them, quite clearly, had encountered since coming to the United States. The difficulty and discomfort which these participants experienced in regard to the categories for ethnicity customarily used in the United States suggest serious attention be devoted to examining and de-centering these categories. Some examples will help to illustrate this point.

Overall, participants who had been born and raised in the U.S. were able to use standard categories for ethnicity readily and decisively, although they were not always comfortable with these categories. However, participants who were not born and raised in the United States displayed difficulty in trying to fit their own identifications of their ethnicity into these standard categories. For example, Jack, the male participant born in Monterey and raised in San Francisco, immediately replied, "Caucasian" and made no other comments on this topic. Similarly, Paris, the male participant from Virginia, replied "Black" without offering any further elaboration, and Bob, a male participant also from the San Francisco area, replied, without pause or hesitation, "White". Bianca, born and raised in Queens, New York, also had a fairly simple answer to this question. Although Bianca asked "Do you mean race?", she immediately went on to say, "Caucasian" before I could answer

her question. Alasdaire, born in New York City and raised there and in New Jersey, also had a fairly direct, if slightly hesitant, answer to this question, saying, “White, I guess”.

However, other participants born and raised in the United States provided answers to this question which suggested that they were not able to so easily fit their own experience into the standard categories for ethnicity. For example, Finn, born and raised in Amherst, Massachusetts, provided a more complicated answer, saying, “Well, kind of European. Mostly English, Irish, German, Dutch. Many generations have lived just in New England.” Julie, born and raised in upstate New York, had a similarly complicated answer to this question, responding in a questioning tone of voice, “Caucasian?”, then going on to say, “French Canadian and just a little Irish- and, who knows?” Bertha, born in Hoboken, New Jersey and raised partly in Israel and partly in Massachusetts, said, in one continuous statement, “Jewish, Semitic, Caucasian, ‘Other’”. Jan, raised mostly in a borough of New York City, had a similar answer, saying, “White Jewish, Caucasian”. Interestingly, Jack, a male participant from San Francisco, identified his religion as Jewish but did not connect this to his answer of “Caucasian” regarding ethnicity.

All the participants who were not born and raised in the United States provided even more complex answers to this question. For example, Sergei, born and raised in St. Petersburg, USSR, answered all at once, “White, Caucasian. Jewish-Russian-American, culturally. Born in St. Petersburg”. Zum, born and raised in an urban area of western Turkey, said, “Caucasian”, first, but went on to emphasize, “Turkish, that’s how I think of myself”, then added, “White”. Somewhat

similarly, Olivia, born in Colombia, and raised there and in Queens, New York, said, “Hispanic is the category I would select. But, Colombian-American is the way I think of myself”. Luke, born in Brazil, had an even more complex take on this issue, answering, “Brazilian”, but adding, “I usually check ‘Other’ because my ethnicity is ‘mixed’”, and going on to say, “I do not consider myself ‘Hispanic’ because that is more than one race”. Cathy, born in Hong Kong seemed to confront a similar issue in regard to standard categories for ethnicity, saying, “Asian-Chinese is my self definition. I check ‘Asian’ when I am forced to choose a category.”

The answers of Anya and Georgina displayed similar discomforts with standard US categories for ethnicity. Anya, born and raised in Prague in the Czech Republic, said, “Czech-100% is how I think of myself. When I am forced to choose, I check the box for ‘Caucasian’ or ‘White-non-Hispanic’”. Georgina, from Hungary, said, “I have only thought about this since coming to the USA. For twenty four years before, this was not an issue. I didn’t think of myself in these terms. Now, I think about this in terms of my cultural background, Hungarian-European. I leave the space blank when I am forced to select a category.”

Finally, three participants, Sooty, the female participant of East Indian heritage who was born and raised in London, England, Archis, born and raised in Barbados, and Kawika, the male participant of Japanese-German descent born and raised primarily in Japan, brought up even more convoluted patterns of connections to place and ethnic identity. Sooty described her complex perception of her situation as a person born in London but of East Indian descent, saying, “Indian is my self definition. But, I usually choose ‘Other’ because in the USA ‘Indian’ refers to Native

Americans and I am not a Native American. 'Asian' is too general. It includes people from Turkey, Iran, China, Russia, Southeast Asia, Japan." Archis' answer was very emphatic, and also complex. She said, "Caribbean person. I sometimes check 'Black', but mostly 'Other'. I never select 'African-American'. In NO WAY am I American!" (the strong emphasis was hers). Kawika's response illustrates most dramatically the complexity of relations between place, ethnicity and identity in participants' answers to this question. Kawika, of Japanese-German descent, explained his view of his ethnicity, saying, "Japanese-German. I also consider myself 'Other' or 'Pacific Islander', although I wasn't born on a Pacific Island. However, I lived in Hawaii for a short time and many people there are of the same mixture of races as I am." He also explained that he chose the name "Kawika" because it is Hawaiian for "David", a name which he likes.

There was also a surprising diversity to the participants' responses about their religions. As explained in detail in the chapter devoted to methodology, at the beginning of the interviewing it became evident that a question on religion was needed. As can be observed in quotes from participants' presented above, participants did not always distinguish between ethnic and religious identifications. In order to clarify what the participants were saying about their ethnic identifications, a question asking about participants' religious affiliations was added, especially since it seemed possible that both ethnicity and religious beliefs might play a role in the way participants dealt with experiences of pain.

Six of the women said they either had no religion or did not subscribe to any formal religion. Three of these six women, Archis, from Barbados, Zum, from

Turkey, and Anya, from the Czech Republic, simply said that they had no religion. Another of these six women, Olivia, from Colombia, said that, although she had been raised Roman Catholic, she now had no religion. Finally, Julie, who comes from Albany, New York, said, “ I don’t have an organized religion, but I believe in God. I pray every day”. Julie connected her religious beliefs to her experiences as a member of Alanon, a twelve step program with a religious orientation for adult children of alcoholics. Three of the other five women identified their religions as “Jewish”: Bianca, born and raised in Queens, New York; Bertha, born in Hoboken, New Jersey, but raised mostly in Israel; and Jan, born in Pennsylvania, but raised mostly in a borough of New York. One woman, Cathy, born and raised mostly in Hong Kong, identified her religion as “Christian”. Finally, Sooty, the woman of East Indian descent born and raised in London, identified her religion as ‘Hindu’.

In regard to religion, the men’s answers also displayed heterogeneity and intricacy. For example, Paris, born and raised in Virginia, identified his religion as, “Divine Faith, which means that I believe that all religions basically have similar beliefs and I believe in these similarities”. Two of the eight men responded quite straightforwardly, using only the single word “Jewish”, including Jack, from San Francisco, and Sergei, born and raised in St. Petersburg, USSR. Alasdaire, born in New York City, identified his religious heritage as both Jewish and Lutheran, but stated that he did not adhere to either organized religious tradition, saying, “Half Jewish, my Dad, and half Lutheran, my mother, but neither, Independent”.

Three of the remaining four men said that they had been raised as Catholics, but no longer practiced this religion. One of the three, Luke, born and raised in

Brazil, identified his religion as “agnostic”, but went on to acknowledge some continuing allegiance to Catholicism, saying, “I was raised and baptized a Catholic. Now I guess I am a secular, non- church going Catholic”. Finn, born and raised in Amherst, Massachusetts, also identified himself as an agnostic, saying, “ I was brought up Catholic, but, I guess, I’m agnostic. I was Catholic to the age of nine”. The third man, Kawika, of Japanese- German descent, said, “ I was raised Roman Catholic. Now I believe in God, but according to personal beliefs rather than organized religion”. Finally, Bob, the computer programmer and analyst from the San Francisco Bay area made no reference to his family’s religious orientation but said he had no religion, replying, “Not really anything”.

Table 1: DEMOGRAPHIC CHARACTERISTICS OF PARTICIPANTS IN STUDY, WOMEN part 1

	Archis	Zum	Olivia	Julie	Sooty
Age	24	25	27	27	28
Place of Birth	Barbados, and NOT the capital city, Bridgetown	Izmir, Turkey	Colombia	Albany, New York/ Saratoga County, New York	London, England
Own Identification of Ethnicity	“Carribean Person. Sometimes I check ‘Black’, mostly ‘ Other’. I never select ‘African-American’. in <u>NO WAY AM I AMERICAN!</u> ”	“‘Caucasian’ (said this first, however, emphasized) ‘Turkish’. It’s how I think of myself. White”	“‘Hispanic’, the category I would select. ‘Colombian-American’ is the way I think of myself.”	“Caucasian ?(said in questioning tone) French-Canadian and just a little Irish- and who knows?”	“‘Indian’ is my self definition. I usually choose ‘Other’ because in the USA ‘Indian’ refers to Native Americans and ‘Asian’ is too general.”
Education- Highest Degree Completed	B.S., which she just received.	Master’s	B.A.	B.S.	Master’s
Religion	No answer	None	None- raised Roman Catholic	I don’t have an organized religion, but I believe in God. I pray every day.	Hindu
Marital Status	Single	Single	Married	Single	Single
Type of Employment	Office work in friend’s mother’s office. Full time.	Part-time secretarial work/ Full time student	Research interviewer- temporary worker	Mid wife assistant- lab work and work at a Writing Center as a writing tutor	Research Assistant- Neuropsych Lab
Income	under \$10,000	\$21,000-\$30,000	\$21,000-\$30,000	\$10,100-\$20,000	under \$10,000

Table 1: DEMOGRAPHIC CHARACTERISTICS OF PARTICIPANTS IN STUDY, WOMEN part 2

	Bianca	Cathy	Anya	Georgina	Bertha	Jan
Age	30	31	35	36	43	48
Place of Birth	Queens, New York	Hong Kong	Prague, Czech Republic	Gyor, Hungary	Israel	New York City
Own Identification of Ethnicity	First asked: "Do you mean race?", then said "Caucasian", before I answered.	"Asian-Chinese is my self-definition. I check 'Asian', when forced to choose a category."	"Czech-100%", is how I think of myself. When forced to choose, I check the box for "Caucasian" or "White, non-Hispanic."	"I have only thought about this since coming to the USA. For 24 years before, this was not an issue. I didn't think of myself in these terms. Now, I think about this in terms of my cultural background-Hungarian-European". I leave the space blank when I am forced to select a category."	"Jewish. Semitic. Caucasian. 'Other'."	"White. Jewish. Caucasian."
Education-Highest Degree Completed	Master's, which she just received	B.B. A. (Bachelor's Degree in Business Administration)	Master's	B.A., which she just received.	Master's Degree. Is about to complete Doctorate	Ph.D.
Religion	Jewish	Christian	None	Raised Roman Catholic. Now, has no formal religion, but believes all religions respect the same, basic principles.	Jewish	Judaism
Marital Status	Married	Married	Married	Single	Single	Married
Type of Employment	Research Assistant	Research Assistant, helps with library research/ Teaching as adjunct professor, part time.	Just lost job, due to funding cut. Worked at the League for the Hard of Hearing as Research Assistant.	Activities Co-ordinator for Supportive Housing. They offer 24hour support to people with a range of difficulties, including AIDS, mental illness, substance abuse problems.	No. Is a full-time Graduate Student	Research Professional
Income	\$61,000-\$80,000	\$81,000-\$100,000	Over \$100,000.	\$21,000-\$30,000	Under \$10,1000	\$61,000-\$80,000

TABLE 2: DEMOGRAPHIC CHARACTERISTICS OF PARTICIPANTS IN STUDY, MEN part 1

	Sergei	Finn	Paris	Bob
Age	35	36	38	41
Place of Birth	St. Petersburg, USSR	Amherst, Mass.	Virginia, USA	Born in Berkeley, CA, raised in San Rafael, north of San Francisco
Own Identification of Ethnicity	"White-Caucasian. Jewish-Russian-American. Culturally, born in St. Petersburg	"Well, kind of European, mostly English, Irish, German, Dutch; many generations just in New England."	"Black" was all he said. He seemed to find this sufficient.	"White."
Education- Highest Degree Completed	Has Completed B. A.	B.A.; currently working on M. A. in Literature.	High School Diploma; Has also had two years of college at a four year college.	B.A. in Computer Science
Religion	Jewish	Brought up Catholic, but guess I'm agnostic. Was Catholic to the age of nine.	"'Divine Faith' which means that I believe all religions basically have similar beliefs and I believe in these similarities.	"Not really anything"
Marital Status	Married	Single	Single	Married
Type of Employment	Teaches part-time, as an adjunct professor/ works in a sleeping lab as a Technician	Co-ordinator of ESL computer lab and in charge of staff of ESL tutors. Prepares students for entry level essay exams.	Just beginning a job with a food delivery service which delivers food which customers order over the Internet to their homes.	Computer programmer and analyst
Income	\$51,000 to \$60,000	\$81,000 to \$100,000, although at the time, last year, he was living with a girlfriend, so this was a combined income. (Now is probably more in the \$41,000 to \$50,000 range).	under \$10,000	\$61,000to \$80,000

Table 2: DEMOGRAPHIC CHARACTERISTICS OF PARTICIPANTS IN STUDY, MEN part 2

Participant	Alasdaire	Kawika	Luke	Jack
Age	25	29	31	33
Place of Birth	Born in New York City; Raised in New York City and New Jersey	Japan	Brazil	Born in Monterey; Raised in San Francisco, CA.
Own Identification of Ethnicity	"White, I guess."	"'Japanese-German'. I also considers myself 'Other' or 'Pacific Islander'. Although I wasn't born on a Pacific Island. However, I lived in Hawaii and many people there are of 'mixed race'."	"'Brazilian'. I usually check 'Other' because my ethnicity is 'mixed' I do <u>not</u> consider myself 'Hispanic', which is more than one race."	"Caucasian (answered immediately, made no other statements on topic)"
Education-Highest Degree Completed	B.A. in Philosophy	Has Completed Master's	Has Completed B.A, is just starting Master's Program.	MFA, " terminal degree in acting."
Religion	Half Jewish- Dad, Half Lutheran, Mother, but neither, Independent	Raised Roman-Catholic; believes in God, but according to personal beliefs rather than organized religion	"Agnostic"/ was raised and baptized a Catholic/ "Secular, non-churchgoing Catholic	Jewish
Marital Status	Single	Married	Partner, but lives alone	Single, but lives with a partner
Type of Employment	Writing tutor: Also does freelance writing; Works for a composer, dealing with his computer issues as a kind of consultant	Not able to work because of work authorization issues related to Visa status	Manages injury data for municipal agency	Field events manager for a food company based in California, does food demonstrations, showing clients how to show and manage the products.
Income	\$21,000 to \$30,000	\$41,000-\$50,000	\$31,000-\$40,000, just increased since November (the interview was in July) from \$10,000 to \$20,000	\$61,000 to \$80,000

INTRODUCTION TO CHAPTERS FOUR, FIVE AND SIX

The following three chapters, Chapters Four, Five and Six, all report results. Each of these three chapters reports the major themes which emerged when particular methods and analytic strategies were employed. Chapter Four presents themes which emerged when an overall content analysis was conducted across five sections of the interview: the introductory section asking for demographic information, the Narratives Protocol, the Map Drawing Protocol, the Life Story Interview and the concluding open-ended questions. Chapter Five presents the results obtained by intensively examining how five research participants, over the course of the interview, portrayed the ways in which pain figures in each of their lives, drawing on data obtained in the same five sections of the Interview as Chapter Four. Chapter Six presents the major themes resulting from detailed analyses of the Narratives, the Maps, and the Coping Skills Questionnaire (CSQ), the standardized questionnaire which participants were asked to complete.

The results are organized in three separate chapters according to the specific methods and analytic strategies used to address two major concerns. First, this research is an exploratory study. A presentation of results tied closely to the data obtained using specific methods and analyses makes the findings clear to the reader, allowing the researcher to illustrate and substantiate the bases for her claims that these themes are present in the data. Second, each method used provided a unique perspective on the research participants' experiences, which could not be captured without separate presentations of the results obtained using different methods and analytic strategies.

Each of these three chapters ends with a brief summary of how the material in the chapter answers the research questions.

Chapter Four

OVERALL PATTERNS OF PAIN IN EVERYDAY LIFE

INTRODUCTION TO THE CHAPTER

The main objective of this chapter is to present the reader with a comprehensive view of the results obtained by conducting an overall content analysis. This content analysis draws on information obtained in five sections of the Interview, including: 1) the introductory section, which asks for basic demographic information using close-ended and brief open-ended questions, 2) the introduction to and follow-up questions of the Narratives Protocol, 3) the Map Drawing Protocol, 4) the Life Story Interview, and 5) participants' comments in the open-ended, closing section of the overall interview. Results that pertained to all participants, both women and men, regardless of ethnicity, are presented first. Next, results illustrating differences between women and men are reported. This is followed by a brief section which addresses issues which seemed to be important to the way women construct their experiences of pain but which came up in only a single interview so did not merit inclusion as themes. The chapter ends with a discussion of how the information provided by this method and analysis answers the research questions.

SIX SIMILARITIES IN PARTICIPANTS' CONSTRUCTIONS OF PAIN

The overall content analysis of the interviews revealed six ways in which participants' constructions of pain were remarkably similar, regardless of gender.

First, most participants displayed an awareness of the dualistic, biomedical construction of pain into separate realms of the physical and emotional. Second, participants chose to discuss a wide range of types of experiences of pain. However, third, none of the participants was able to maintain a distinction between physical and emotional pain throughout the entire interview. This is especially interesting because the bifurcation between physical and emotional pain is such a pronounced feature of the Western, biomedical model of pain. Yet, even though most participants did display an awareness of this dualistic biomedical construction of pain into separate realms of the physical and emotional, even employing this distinction at times, not a single participant was able to continue to bifurcate physical from emotional pain throughout the course of the interview. Fourth, not only were participants unable to limit their descriptions of pain to physical pain, but all the participants connected pain to many aspects of their lives. Fifth, for all participants, it appeared that the way in which their families dealt with pain as they were growing up was closely related to the way in which participants described themselves dealing with pain as adults. Sixth, both female and male participants talked about pain not only as a personal, individual, self-contained experience, but also in terms of experiences of “collective” and “shared” pain, pain experienced on behalf of others or shared with other people.

First, most participants demonstrated an awareness of the biomedical distinction between physical and emotional pain.

When participants were asked to tell the researcher about some of their experiences of pain in the course of everyday life, at the beginning of the Narratives Protocol, the majority of participants did display a recognition of the biomedical distinction between physical and mental pain. Many participants asked whether when I said “pain” I meant only physical pain, or whether I meant either physical or emotional pain. For example, Luke, very early in the interview, asked, “Do you mean physical?”, while Paris, while I was still asking the questions on demographic information, asked, “Physical or emotional?”

When they were told that this interview concerned their experiences of pain, what they themselves meant by pain, the majority of participants proceeded to include experiences of both physical and emotional pain. For example, Zum said, “Physical pain is different from emotional pain. Which do you mean?” When she was told that she could talk about what she meant by pain, Zum looked quite noticeably surprised and pleased. Similarly, Anya asked, “Do you mean physical or emotional pain?” adding, “Emotional pain is (her emphasis) pain.” After mentioning two experiences of physical pain, Anya repeated, “Emotional pain is pain.” adding, “Mental pain is so different.” She proceeded to mention two more experiences of pain which she regarded as more emotional, the pain of family issues, in particular her parents’ divorce when she was ten years old, and, later, when she was twenty years old, the pain of immigration to the U. S.

Second, participants chose to discuss a wide range of types of experiences of pain.

Both female and male participants chose to discuss a wide range of experiences of pain in both their Narratives and Maps. Some participants chose to write about one more physical experience of pain and one more emotional experience of pain (see Table 3). For example, for her first Narrative, Bianca chose to write about a more emotional experience of pain, the death of her grandmother, while for her second Narrative she wrote about a physical injury to her foot. Archis chose to write about pain from a groin injury for her first Narrative and pain from being touched for her second Narrative. Luke chose to write about “body pains, muscular and joint” for his first Narrative and an experience of “anxiety” for his second Narrative.

However, in their Narratives, some participants chose to write about two experiences which were both more related to either physical or mental pain. For example, Zum chose to write about a recent experience of chest pain for her first Narrative and cramps related to her menstrual period for her second Narrative. Jan chose to write about an experience of back pain for her first Narrative and labor pain for her second Narrative. Finn chose to write about his painful experience of having to grab some curtains which were on fire for his first Narrative and a time when he was severely sick for his second Narrative. On the other hand, Sooty chose to write about her more emotional “bi-cultural experience” especially, “not being married according to the custom of arranged marriage” for her first Narrative and another more emotional experience of pain,

“living in New York City, far from my family in London”, for her second Narrative.

Alasdair chose to write about the “pain of not working on music” and the “pain of working on music” for his two written Narratives. Julie chose to write about her experience with her first boyfriend, which she described as “an experience which was really the bottom for me” for her first Narrative and “reliving the painful experiences of growing up with alcoholism in order to get over them” for her second Narrative.

Participants’ choices for their two drawings in the Map Drawing Protocol reflected a similar diversity. Several participants chose to depict experiences of both physical and mental pain. For example, for her first Map, Zum made a drawing of herself in bed because she was, in her words, “expecting bad news related to my father”, while for her second Map she chose to depict an experience of severe ear pain. Sergei chose to depict a scene in which he was hit in the mouth with a stick for his first Map and, for his second Map, a scene which he described as “more of mental pain” in which he became involved in a fight with an older boy because he had spread rumors about that boy’s girlfriend. Anya depicted her experience of pain associated with a severe eczema condition during her childhood in her first Map and a scene portraying her difficulties getting along with her mother during her adolescence for her second Map.

However, some participants depicted two experiences of physical pain in their Maps. Archis depicted a scene in which “my little brother threw a stone and hit me under my left eye” for her first Map and an experience of pain due to a fall on a large, slippery rock on the beach in her second Map. Olivia portrayed her

experience of falling and hurting her knees in the concrete yard of her caretaker for her first Map and an experience in which her lips were badly sunburnt due to riding in an open car for her second Map.

Other participants chose to depict two scenes related to more emotional experiences of pain. Alasdaire depicted the pain of returning to the family group after “storming upstairs because I got really angry” during his childhood for his first Map and, for his second Map, a scene in the corridor of the public high school he attended in which he was being led back into Spanish class after being suspended for non-attendance. Bianca depicted two experiences of emotional pain, a scene in which she was “trying to reach through the bars [of his crib] for my baby brother’s pacifier” for her first Map and a scene in which “I had to remain at home while my first real boyfriend went away to college” for her second Map.

However, third, none of the participants was able to maintain a distinction between physical and emotional pain throughout the course of the interview nor was any participant able to limit his or her discussion only to physical pain.

Surprisingly, even though some participants did initially try to limit their descriptions to physical pain, none of the participants, regardless of gender or ethnicity, was able to maintain a bifurcation between physical and emotional pain through the entire interview. All the participants eventually included experiences of mental and emotional pain in their constructions of their experiences of pain.

This finding was especially striking because the distinction between physical and emotional pain is such a key feature of the Western, biomedical model.

This rather surprising finding is demonstrated particularly effectively by the interviews with three participants, Kawika, Finn and Bob. While many of the participants combined emotional and physical pain in their descriptions, these three male participants attempted to adhere to a distinction between physical and emotional pain and to limit their discussions to their experiences of physical pain. However, none of these three male participants was able to maintain this distinction throughout the entire interview which makes the point even more strongly that participants were not able to maintain a distinction between physical and emotional pain. An examination of the interviews with these three male participants will help to both demonstrate the difficulties they encountered in trying to maintain the distinction between physical and emotional pain and illustrate the ways in which all of the participants formed connections between physical and emotional experience. It is especially noteworthy that all three of these male participants began to connect physical pain to emotional pain at the same point in the interview, the second Map Drawing. Although all three of these participants were able to limit their discussions to experiences of physical pain for both their Narratives and for their first Maps, they all began to connect physical pain with emotional pain, without at first realizing it, when they were asked to draw their second Maps in which they were asked to depict an experience of pain which occurred when they were ages twelve through seventeen.

The three male participants who tried to adhere to a bifurcation between physical and emotional pain came from very diverse backgrounds and were living quite different lives. Kawika is the twenty-nine year old male who identified his ethnicity as Japanese-German, adding that he also circles “other” on official forms and sometimes chooses the category of “Pacific Islander” because he has lived in Hawaii and found that there are many people there of the same ethnic mixture as himself. At the time of the interview, Kawika had already earned a Master’s degree but was unable to work in the United States due to visa restrictions. Finn is the thirty-three year old male who was running a writing lab while working on his Master’s degree and described his ethnicity as “ kind of European”, going on to add “English, Irish, German, Dutch,” and to say that his family had been in New England for many generations. Bob is the forty-one year old computer programmer and analyst born and raised in the San Francisco Bay area who identified his ethnicity as “ White” and described himself as “not having a lot of words”

Kawika himself raised the issue of whether I was referring to physical or mental pain. Very early in the interview, at the beginning of the Narratives Protocol, when I asked him to name some experiences of pain in his life, he stopped in the midst of relating these experiences to explain that, when he first heard the word “pain”, when I gave him the Consent Form and was explaining the study, he thought of physical pain. He went on to say that, after mentioning five of his experiences of pain, he found himself thinking that he had better ask if we were only talking about physical pain. However, he followed this question

immediately, without waiting for me to respond, with the statement that he intended to comment only on experiences of physical pain, saying, “I will just leave it at just physical pain for the moment. Physical will do for now. It’s what I thought of when you asked the question.”

Kawika wrote about having a stomachache for his first Narrative and about an injury to his knee which occurred during the cross-country running season for his second Narrative. Kawika’s first drawing was of an experience when he fell while riding his bicycle with his mother on their way to a pool to go swimming and hurt his leg, which he said occurred when he was about eleven years old. He described this experience only in terms of physical pain (see table 3). However, for his second Map drawing, Kawika chose to depict an experience in school which he himself identified as emotionally troubling.

On the other hand, Finn did not raise the question of whether the interview referred to physical or emotional pain, but appeared to assume that only physical pain was being discussed. Finn initially selected experiences of pain which would usually be considered to be physical pain and described these experiences of pain solely in terms of physical pain. For his first Narrative, he wrote about using his bare hands to try to put out curtains which had caught fire. For his second Narrative, he wrote about an experience in which he had a bad case of strep throat while visiting his grandparents on an island off the coast of Canada where there were no doctors. In his first Map, he chose to depict an incident in which he cut his hand while playing in a parking lot, in the wheel well of a large truck. He was near the end of the interview, in the Life Story section,

before he himself remarked that he was having difficulty limiting his comments solely to physical pain. At this point in the interview, he commented that the experience he was discussing, a break-up with a girlfriend, would be more likely to be classified as emotional pain. However, Finn had actually begun discussing a more emotional experience of pain earlier in the interview, while he was drawing his second Map, of an experience when he fell while skate-boarding down a “really, really steep hill”.

Like Finn, Bob did not ask whether I meant physical or emotional pain. He just seemed to assume that I was referring to physical pain. He wrote his first Narrative about his recent experience of getting cramps in his foot while lying in bed and his second Narrative about running into a pole on a basketball court when he was around the age of ten. For his first drawing, he elected to draw this same experience, of running into a pole on a basketball court. Bob was like both Finn and Kawika in that all three of these male participants began to combine “emotional” pain with “physical” pain without appearing to realize it. In addition they all began to combine “emotional” and “physical” pain at the same point in the interview, the second part of the Map Drawing Protocol. At this point in the overall interview, when each was asked to think of an experience of pain which occurred when he was ages twelve through seventeen, all three began to include what could be considered as more “emotional” pain in their descriptions of the experiences they illustrated. Kawika himself eventually observed that he was no longer discussing only experiences of strictly “physical” pain, commenting that he was unable to adhere to his self-imposed limitation of talking only about physical

pain. He noted that, although when I mentioned the word “pain” his immediate association had been to physical pain, he now realized that the trouble in school he had depicted in his second drawing was not what would generally be considered as physical pain.

In his second drawing, Kawika depicted a scene in which he described himself experiencing emotional distress and feelings of what he termed “alienation” in regard to his situation in school. Saying he was illustrating a scene in his early adolescence when he was not doing very well in school, he drew himself holding a piece of paper with a large, red letter “F” on it. He explained that he was very afraid that he might fail this grade, a fear which was exacerbated because students at this school were frequently held back. In addition, he described himself at this point in his life as not only afraid that he might fail, but also as feeling alienated. He explained that the other children at this school had parents who either worked for German corporations based in Japan or had government related jobs. However, he was attending this school because of his mixed ethnic heritage, his father being Japanese and his mother German. He revealed that this made him feel different and alienated. Thus, by this point in the interview, the second drawing, which occurs approximately halfway through the interview, Kawika found himself including emotional pain in the experiences he described, rather than limiting himself to experiences of physical pain. By the time we got to the Life Story section of the interview, Kawika had widened his discussion of pain in his life to incorporate a much broader array of issues, including his experience of what he called “ the

existential pain of life". When queried, he said about this existential pain "It is very hard to define. It almost feels like frustration".

Finn, in his second Map, depicted a scene in which he was skateboarding down what he himself described as a "really, really steep hill". He said that he fell and scraped his back rather badly, probably because he hit a big stone, which he characterized as an "evil stone". Finn explained,

Oh, I remember one thing. I was skateboarding down a really, really steep hill. I was wearing a backwards baseball cap, I think (said as he draws it). And, I fell really badly. It was because I was going really fast. And, I think, yeah, then I scraped a bunch of skin off my back. I sort of left a lot of skin on the hill. I was with a couple of people who were better at it than I was. My friends said, "Are you OK?" I didn't go to a hospital. I probably didn't need to go. I got the gravel out of my skin. It took about two hours. The scrapes were bad.

However, toward the end of his explanation of this scene, Finn spontaneously mentioned that this experience had been "really embarrassing" because the two friends with whom he had been skateboarding, and whom he had depicted standing at the bottom of the hill waiting for him, had made it down the hill, while he had not. He stated that he thought that the embarrassment might have been the real significance of this experience, saying,

Painful? It was. But, I think of it more as embarrassing. I think it was probably more of an embarrassment at the time. (He draws some more, adding more detail to the drawing). More embarrassment. I thought of physical pain, but how I think of the memory- more embarrassment than pain comes back to me.

At this point in the interview, Finn did not notice that he had mentioned a more emotional aspect of pain. Later in the interview, in the Life Story section, where participants are asked to reflect on their overall life experiences of pain, Finn talked about the pain of breaking up with his girlfriend. It was at this point that he mentioned that he had thought he would only discuss physical pain, but now realized that he could not avoid mentioning emotional pain. I pointed out that, earlier in the interview, when he was drawing his second Map, I thought I had heard him mention an experience of what is usually considered to be more emotional pain, the experience of embarrassment, as a significant part of the pain of his experience skateboarding on the very steep hill. Finn immediately agreed. He proceeded to express a great deal of interest in the idea that emotional and physical pain might not be so easily separated and he himself initiated a discussion of the link between physical and emotional pain. He disclosed that, “ At the beginning, I intended to stick with physical pain., not qualifying it. I just thought ‘pain’ referred to my physical pain.”

Bob decided that, for his second drawing, he would depict what he termed “something else”, something different from foot cramps, the subject of his first Narrative and running into a pole, the subject of his second Narrative and first Map. Saying, “Do you want me to think of something different? Football? Maybe something else? Yeah, I’ll do something different.”, Bob went on to make a drawing which he said depicted his experience of “ Just getting drunk, going to sleep, waking up with a hangover, getting up and lying back down.” At this point, Bob added two semi-circular shapes with arrows, which, he explained,

represented “repeating”. He went on to explain that this began when he was sixteen years old and continued until he was thirty-four. Asked if he could explain why this happened, Bob answered, “ I was an alcoholic”. Asked if this experience mattered to him, Bob replied,

Yeah. It was a big chunk of my life. And, you know, see, maybe I loved drinking. It took a long time to not get hangovers. I didn’t get hangovers when I was drinking every day.

Bob added that this occurred “Any place. Wherever I was Friday and Saturday nights when I was in high school. I could get drunk anywhere, and did.”

Like Kawika and Finn, Bob had assumed that he could limit his comments solely to experiences of physical pain, but had begun to talk about an experience of pain more likely to be considered mental or emotional pain, the experience of alcoholism. Bob also introduced this more emotional experience of pain at the same point in the interview as Kawika and Finn, while he was drawing his second Map. Like Finn, Bob did not appear to notice his introduction of a more “emotional” form of pain at the time.

Near the beginning of the Life Story interview, when the participant is asked if there are any major experiences of pain she or he has not mentioned, Bob at first replied, “Probably not. Let’s see. Not that I can think of off the top of my head.” However, Bob had mentioned, when asked if he took medication, that he takes three antidepressant medications to help him deal with depression. I mentioned that he had provided this information regarding medication and asked whether he would consider his experience of depression as pain. Bob replied,

Depression? Yeah. A big chunk of pain. It was, is,.. it isn't anymore. I never thought of it before. I mention...mental pain I don't associate it as being pain. But, ask me now, I would qualify it as pain.

A little later in the interview, when asked “Does this way of looking at your experience of pain make any difference to you, to your life?” Bob replied by trying to explain the effect the recent idea that physical and emotional pain might not be entirely separate had already had, saying,

Depression. I never thought of depression as pain. I find it interesting. But I don't see it changing anything. It's new. It's not helpful, but it's interesting. Real pain versus newly found depression pain. I've always put them in separate boxes. It's more like trying to figure out what pain really is. I still tend to think... depression and pain are separate, but not as much as I would have before. When I hear “pain”, I think “ouch”.

While Bob clearly found the question of whether depression can be considered as pain interesting, unlike Kawika and Finn, he did not immediately abandon his view of pain as clearly bifurcated into physical and mental pain. The quotation above illustrates Bob's ambivalence. However, when asked to complete the CSQ, the standardized pain questionnaire which participants were asked to complete at the end of the interview, Bob asked if he could complete the scale in two ways, once with “my old idea of pain” and once with “my new view of pain”. Since one of my major interests in including the standardized scale was to see how participants' ways of constructing their experiences of pain in the interview related to their responses on the scale, I agreed (see Chapter Six for a discussion of Bob's responses to the CSQ). As Bob put it, continuing to display some ambivalence,

It didn't originally come to mind. But, it was, actually, a huge part of pain in me. I still can't put them together. But....I can't shift my perspective that fast.

During the course of this interview, Kawika, Finn and Bob eventually came to realize that they were not able to maintain a separation between physical and emotional pain. All three of these male participants first began to introduce more "emotional" forms of pain while they were drawing their second Maps, in which they were asked to think of an experience of pain which occurred when they were ages twelve through seventeen. Each of these three participants eventually remarked on his own inability to keep the domains of physical and mental pain entirely separate. When Kawika became aware that he was talking about aspects of pain which would not usually be considered as "physical" pain, he was talking about a school experience in which he was afraid of failure and experienced alienation. When Finn first introduced a type of pain which would not usually be considered "physical" he was discussing an experience in which he felt embarrassed about the quality of his performance in a sports related activity. However, Finn became aware that he was not limiting himself to physical pain in the Life Story portion of the interview, when he began to talk about his experience breaking up with a girlfriend. Bob first introduced the topic of alcoholism as "something different" when he chose this topic for his second drawing and went on, in the Life Story section of the interview, to talk about his experience of depression, a more mental type of pain, as a possible experience of pain.

A fourth major finding was that not only were participants unable to limit their descriptions of experiences of pain to physical pain, but participants connected pain to many aspects of their lives.

This finding may be particularly interesting in light of an issue frequently raised by researchers studying chronic pain (Kleinman, 1986; Kotarba, 1983), who question how so many aspects of life seem to become connected to the chronic pain sufferer's experience of pain. In this study of everyday pain, in which participants were especially screened to avoid recruiting people with experiences of pain which would qualify as chronic or clinically significant pain, it was not only the case that none of the participants was able to adhere to the biomedical distinction between physical and emotional pain. Beyond this, all participants connected their experiences of pain to other aspects of their lives in many ways.

I have described the connections Kawika, Finn and Bob made between emotional and physical pain in their portrayals of their experiences in their second drawings. Two other male participants, Paris and Sergei, made explicit comments on the connections between physical and emotional pain. Like Kawika, Finn and Bob, they commented on the connections between physical and emotional pain when asked to draw the second Map. Paris actually refused to make this second drawing, explaining, "By this point, you learn that daily physical injuries are not a big deal", but that emotional and mental pain began to be more important.

Sergei elaborated on this idea while talking about his second Map. He chose to depict a school experience in which he was beaten up by another boy because he had helped to spread negative comments about that boy's girlfriend.

As Sergei said,

That age group. Not pain, I thought more of mental pain. I started to deal more with real life. In childhood, an accident is a big deal the first time. But, you get used to it. Two years from now, I won't remember the fall from the tree [the topic of his first Narrative].

Sergei went on to connect this experience to many other aspects of his life. He explained that the pain he felt during this experience, in which he had talked about the other boy's girlfriend, eliciting the boy's ire and leading to the scene he depicted in the boy's bathroom in which the other boy hit him, was connected to a lesson in life. He said that he learned, "Don't step on other people's toes. Cover your act. Be more careful." He went on to connect this experience to his overall experience of being a Jew in Russia, saying, "You experience all kinds of grief from all kinds of people. You start to realize that people can be pretty crummy." He went on to explain, "We concentrate on the physical too much. There is a more general place of pain in life. More mental pain." Sergei elaborated on this idea further, as he explained that, as a Jew, he had experienced severe discrimination in the USSR, which he perceived as painful. In addition, as a result of these experiences of discrimination, he and his mother decided to emigrate from the USSR, an experience which Sergei also described as painful. Sergei himself made these connections between events in his interview, describing them as a connected and interrelated chain of events.

Kawika was not only unable to limit his discussion of pain to experiences of physical pain. He also went on to connect pain to many other aspects of his life. His discussion of how omnipresent pain was in his life culminated in his talking about what he termed “the existential pain of everyday life”. He described this as an overall experience of pain, a pervasive feeling of angst, which permeated his daily experience of life. Since, at the beginning of the interview, he made the statement that he would deliberately limit his discussion to physical pain, his interview offers an exceptionally compelling illustration of the ways in which participants tied pain to other aspects of their lives.

Fairly early in the interview, while drawing his first Map, Kawika began to mention possible connections between pain and other aspects of his life. Asked if the experience he had depicted in his first Drawing mattered to him, if it was significant in his life, Kawika said, “ In hindsight, it was just an interesting experience”. However, his subsequent comments revealed that this incident seemed to function as a focal point for several important themes in his life at that time, when he was about eleven years old. As Kawika said,

I can still remember it vividly. I can still visualize it, almost in slow motion. I could see the fall coming, but there was nothing I could do about it. It was a relief, considering the fall I took, that I was relatively OK...There was a story behind this The wearing of shorts versus long pants and swimming were two major issues in my life at this time.

Kawika went on to describe how this physical injury related to two disagreements he was having with his mother, the wearing of short pants versus the wearing of long pants and whose preferences should take precedence in

deciding about activities. He explained that one of the reasons he scraped his knee was because he was wearing shorts. If he had been wearing long pants, as he would have preferred, he thinks the injury might have been less severe. Kawika concluded his comments on this first drawing by saying that he also thought that he remembered this experience because it left a lasting mark on his body, a scar he might not have if he had been wearing long pants.

Kawika also explained that his mother looked over the injury and then said that a swim might actually be good for it. At this point, Kawika commented that his mother likes to swim more than he does. He characterized himself saying, “ I am more of a land animal”. He stated, “My mother was trying to rationalize that going swimming, which was what she wanted to do, would be good for me, as well”. He said that he thought the reason why his mother began to “characterize the pool water as being a good antiseptic, to make the pool water seem like more of a ‘treatment’ because the chlorinated water would act as an antiseptic” was because she was afraid that his injury was going to prevent her from going swimming. He also said that he thought that his mother might have been somewhat at fault for the accident itself, saying about responsibility for this accident, “ My mother, perhaps a little bit. Why wasn’t she more careful?”

As mentioned, while talking about his second drawing, Kawika demonstrated his awareness of the relationship between pain and his experience of emotional distress connected with school. He explicitly stated that he realized that the feelings of alienation and emotional distress regarding school which he was discussing would not usually be considered as physical pain. Talking about

his depiction of this scene in which he held a piece of paper with a large, red letter “F” on it, Kawika characterized himself, at this point in his life, as feeling alienated and afraid that he might fail in school.

Several participants connected their school experiences with painful feelings. Luke began portraying pain physically, talking about “body pains, muscular and joint pains” in his first Narrative. In his second Map, he depicted a situation in a gym class in which he experienced more emotional discomfort because of his inability to keep up with the other boys in the gym class. Sooty also depicted a scene in her second Map in which she felt upset and out of place in a school situation. As she explained,

I moved at eleven, to a more middle class area. I went to a new school where I felt like an outcast. I was terribly shy. It was awful, especially the thought of being called on...I was scared to go to school.

Sooty explained further that this school was difficult for her “because it was a new school. I wasn’t adequately prepared in the other school.” Cathy depicted a situation in her second Map in which she fell at school and hurt her knee. She explained that she did not want to go to the nurse because “It was too embarrassing to go to the nurse. People would talk about it. Although the guy I liked at the time told me to go to the nurse”. Cathy said that she finally did go to the nurse, but she did not go home early because she needed to show that she could “take it”, that she would not cry or show weakness, explaining that it was important to her image of herself that she be able to stand pain and not cry.

Finn provided another excellent example of how participants linked physical pain to other forms of pain and to many aspects of their lives. As

mentioned previously, he described his fall while skateboarding, which caused physical pain, saying that this experience was really more connected to an emotional experience of embarrassment at performing more poorly than his friends. He went on to describe the area around the hill, where he had the experience of pain while skateboarding, as a place where he was likely to experience many kinds of pain, a place which formed a nexus of key, and often painful, life events. Finn explained, "I was to experience pain in several different kinds of ways. I went to school there, broke up with girlfriends there."

Several participants connected pain to experiences of losing loved ones. Jack explained how the pain of the death of his grandfather was mitigated by being able to talk for his generation at the memorial service. He explained that this allowed him to share his pain, which he found helpful. Zum described the death of her grandmother, saying, "When my grandmother died, I felt sick. It affected my whole system, emotional, physical, both. Sadness causes pain." Bianca talked about the "many different emotions" she experienced when her grandmother, to whom she was not very close, died. She said that her grandmother's death made her feel bad. In addition, Bianca explained that "What hurt me the most was to see how it affected my father. My grandmother wasn't always the kindest person, especially to my father. Yet, I could see he was really affected by her loss. I guess for me the hardest thing was feeling guilty about not being as close to her as I could have been." And "It taught me that I had to learn to accept the fact that I tried to be close to her, but not to feel bad about the fact that the effort wasn't always returned."

Participants described ways in which experiences of pain connected to many aspects of their lives. In their narratives and drawings, participants frequently portrayed experiences which appeared to be key incidents in their lives, serving to tie many aspects of their lives at the time together. They sometimes portrayed experiences of physical pain which connected to emotional issues. For example, Kawika described his fall from a bike as tying together several themes related to growing up and acquiring greater independence. Finn described a fall on a hill which tied a physical experience of pain together with a feeling of embarrassment and later experiences of emotional pain related to relationships with women and painful school experiences. Many participants described social situations which they found painful. These were often social situations in which they felt concern about how other people thought about or viewed them. Frequently, these experiences involved connections to social institutions, especially schools. Participants also talked about pain related to losing loved ones.

A fifth, major overall finding was that for all participants, both women and men, the ways in which adult members of the family dealt with pain appeared to be an important influence on the ways in which participants described themselves dealing with pain as adults.

For all the participants, the ways in which they described family members dealing with pain while they were growing up related to their own, current ways of dealing with pain as adults. For many participants, the mother's way of dealing

with her own pain and with the participant's pain, particularly when the participant was a young child, seemed to have a lasting effect on the ways in which participants dealt with pain in later life. In some cases, other family members, or even the whole family, appeared to play a formative role in the way in which participants dealt with pain as adults.

During the course of the interview, some participants actually stated themselves that they realized that the way in which family members dealt with pain had influenced their own ways of dealing with pain as adults. Several participants spontaneously commented on the relationship between the ways in which pain was dealt with in their families while they were growing up and their current ways of dealing with pain. For example, Anya said,

You know, doing this interview is making me think that if my mother had dealt with me differently when I experienced pain as a child, I might deal with pain differently now that I am an adult.

As another participant, Georgina, put it,

You know, this has been an interesting interview to do. I never really thought much about pain, and you don't really talk about it much. But, talking about it, I'm beginning to realize that the way my mother dealt with me when I had painful experiences as a child has had a lasting effect on the way I deal with pain.

This was an especially compelling finding because, like Georgina, many of the participants in this study said that they had paid little attention to either the ways in which pain had been dealt with in their families or their own attitudes toward and ways of coping with pain. However, despite their previous lack of attention to this aspect of their upbringing, when they were asked to reflect on

their experiences of pain in life during the research interview, participants reported that the ways in which members of their families dealt with pain appeared to affect their own ways of dealing with pain as adults.

Finn provided a good example of the influence of family ways of dealing with pain. Asked if he could think of anyone in his life who tended to deal with pain in the way he had just described himself dealing with pain, Finn said,

Probably. Yeah. My mom and my brother. I know my brother always denies he is in any pain. Whenever possible. My mom, if she experiences pain, she probably didn't want to burden us kids. So, she was stoic, maybe extreme, a little more. Both just deal and work. Get through it.

Finn's comments earlier in the interview, while drawing his first Map, suggest means through which family ways of dealing with pain might be transmitted. Asked if the experience he had drawn had mattered to him, Finn replied,

No, not really. But I do remember it. It's just what I thought of. Probably every one of these stories are stories I remember and also Mom remembers and we have talked about since. But, certainly, not often. Occasionally, when we reminisce. These are not even family stories. No, they just happen to come up when someone else is around- same kind of story. The T-Ball team I was on or something. I can't remember the last time I talked about something like this. Three times since then. Mom remembers and tells the story. It's partly our memory, partly Mom's story.

Toward the end of the interview, as part of the Life Story Interview, Finn was asked to summarize the ways in which he dealt with pain. As he put it,

How I deal with pain? Yeah. I think I have the New England stoic tendency to be stoic and minimize.

Maybe it's in my family, the tendency to try to take responsibility for your own situation, instead of ---And I don't blame others for things that happen and maybe for pain I have.

The ways in which participants' families dealt with pain appeared to affect the way participants dealt with pain as adults regardless of how the family dealt with pain. Participants reported a wide variety of family ways of dealing with pain. For example, Archis described her family's way of dealing with pain, saying that, in her family, "People often said to just forget about it". She very briefly pondered this statement, then went on to comment that, now that she thought about it, this is what she herself frequently does, " just wait for a couple of days" if she experiences pain. She continued, saying that, in her family, when she experienced pain and it eventually went away, she would be told, " You have just grown out of it". Just waiting for painful conditions to improve appeared to be a key component of the way in which her family dealt with pain when she was a child, which, she reported, has affected her own ways of dealing with pain as an adult.

Archis also chose a somewhat unusual experience of pain, "pain caused by being touched by other people" for her second Narrative. She explained that "It hurts. It really hurts", saying that, " Touching progresses really by little steps to a really other level" and adding, "I really don't like it at all". When asked if she could think of anyone in her life who tended deal with pain in this way, Archis volunteered. " Oh, you mean tend[ed] to react the way I did? I guess so. A lot of people don't like that. Maybe my mom."

Luke explained that his family, especially his mother, used distraction to deal with pain. As he put it, “Yeah, I think that’s ...that’s ..See, I remember my contacts with my early family. When a child falls, they try to distract the child, saying something like, ‘Look at the clown.’” Luke went on to say that his mother also did this herself, “She tried to put herself in a different frame of mind. She would try to distract herself, saying that if she distracted herself, ‘it will go away’”. Luke explained, “ My mother would say not to take medications. Just to forget about it for a few minutes”. If this didn’t work and the pain persisted, his mother would then, sometimes, “resort to medications”. However, for the most part, Luke said that what he remembers his mother doing, was“ Talking about something else. Often, regular, daily activities.”

Sergei, the thirty-five year old man born and raised in St. Petersburg, USSR, began his description of himself and his way of dealing with pain by saying, “I don’t get a lot of pain”. Sergei, who was raised almost completely by his mother, also spontaneously described his mother as “pretty comfortable about pain”. However, when he was talking about his first Narrative, Sergei also said, “ My mother is my family. Something that happened a million times as a kid-rub it”. Sergei explained that, when he was a child and hurt himself, his mother often rubbed the injured area. Later in his interview, while talking about his second Narrative, in which he chose to write about getting a pain in his finger, he said that when he gets this pain, he rubs the finger. Asked why he rubs it, Sergei said “ It seems like the right thing to do.”

Sergei also said that, when he does experience pain, “ I pay attention and try to see what’s going on”. Identifying a cause for pain seemed to be important to Sergei. Asked if anyone in his life had tended to do this when they experienced pain, Sergei said that he didn’t know and had to think back. He then said that he thought his mother dealt with pain in a similar way.

Sooty described very few experiences of physical pain, although she did talk about pain related to her menstrual periods. She explained that physical pain is not much of an issue for her. Sooty portrayed the way in which her family members dealt with pain while she was growing up, saying, “Our Indian family is close and caring. They watch children closely.” She went on to explain,

I know I fell a few times. I scraped my knee. It was nothing. My mother cleaned it up, stopped me from crying. She spoke soothingly and said, ‘It will be alright. It will heal by tomorrow. You won’t feel any pain.’ I believed her.

Georgina described a family situation in which her parents dealt with pain in different ways. She explained that, in her family, she tried to hide pain and injuries from her mother because her mother became “scared and angry” at both her brother and herself when they hurt themselves. However, a little later in the interview, she said that her father often jokes about pain. As Georgina put it, “There’s a story about the dentist. Don’t talk about it. When he [her father] mentioned it, he tried to put it in a funny way. But not mother. She’s very serious. She wouldn’t joke about pain.”

Georgina not only wrote about, but also demonstrated her way of dealing with pain when she was asked to write her second Narrative. She chose to write

about “A new pain. The pain of writing about pain.”, making a joke about the interview itself. Georgina said that she deals with pain, as an adult, by both trying to forget about it and by joking. As she put it,

It is meant always as a joke. Joking is a way to deal with pain. When you joke, it takes your mind off the subject. If you think of pain, feeling the experience of pain makes you uncomfortable. The mind is very powerful.

Toward the end of the interview, Georgina summarized her ways of dealing with pain, saying,

I don't like to think about pain. I joke about my own experience, but not others'. I distract myself. I think about or do something else. Pain, I ignore it and go on."

Sixth, both female and male participants talked about experiences of “collective” and “shared” pain, as well as personal, individual experiences of pain.

Participants did not only describe personal, individual experiences of pain. Both female and male participants also talked about experiences of “collective” and “shared” pain, pain felt for or shared with other people. In the individualisticly oriented culture of the contemporary United States, we seem to pay little attention to the idea of pain which is experienced with or for other people. However, experiences of “collective” and “shared” pain emerged as important themes in these interviews. While these experiences seemed somewhat more likely to be emphasized by participants who were born and raised, at least to some extent, in societies outside of the United States, both female and male

participants born and raised in the United States also described such shared experiences of pain.

Luke, the male participant born in Brazil, but currently living in New York City, depicted a scene from his childhood in his first drawing, emphasizing that he was quite sure that it occurred when he was exactly six years old, the lower boundary suggested for the selection of an experience of pain for this first Map. He said that the scene he was depicting took place in his mother's bedroom, describing the scene as a "sort of fixed object" or image in his memory of it. He went on to explain that he thought this memory had this "fixed" quality because "I didn't understand the context or meaning of the scene until much later", saying that this scene was "one of the most intriguing memories of my childhood" but that it "had no time frame, so it existed in isolation because I didn't understand the surrounding events."

In this scene, he depicted his mother lying in bed. He described her as being "very sad". He then drew the maid, of whom Luke said he was extremely fond, coming out of the bathroom and saying "It's negative". Luke went on to explain that, when he was older, he realized that this scene occurred shortly after his parents' separation. He also realized that the maid was coming out of the bathroom to tell his mother that the results of a home pregnancy test were negative. Luke said he thought he felt pain because of his mother's pain, that it was both himself and his mother who were in pain. He went on to explain that this maid had been very close to both his mother and himself, which made him

think that this was really a scene illustrating pain shared between his mother, the maid and himself.

Sooty, the twenty-eight year old woman of Indian descent, described her experience of being Indian, but bi-cultural, having been born and raised in London, England. During her interview, she talked a great deal about what she referred to as “ the pain of being bi-cultural” and the related painful difficulties she experiences in trying to live up to the different cultural expectations of her family, especially dealing with her family’s plans concerning an arranged marriage for her. The shared aspects of her experiences of pain are most clearly expressed in her comments on her first Narrative and on her two Drawings.

For her first Narrative, Sooty selected the topic of her difficulties dealing with her family’s expectations that she should marry an Indian man from a background similar to hers. She explained that she experiences her own pain as mixed with pain for her family because she is not married at the age of twenty-eight. As she pointed out, in her culture, “This is looked upon almost as a mental disorder”. She described this experience as “ emotional”, “very distressing”, and a pervasive part of her life, saying, “I wake up with this. It never goes away. I live with it constantly”. She explained further, “I face a sort of dilemma”. She said she is sometimes tempted to just agree to an arranged marriage, even though she is sure that she will be “miserable” because it is so painful for her that her family is in so much pain. If she agrees to marry an Indian man from a background similar to her own, at least she will not experience her family’s pain. Finally, Sooty explained, ‘My family is Indian and are members of a collectivist

culture. However, now I live in the US, which is an individual culture”. As a result, Sooty seems to experience both her own, individual pain and pain which she shares with her whole family.

For her first Drawing, Sooty depicted a scene in which her mother is being hit by a robber in the somewhat dangerous London neighborhood where they lived at that time. She illustrated herself with a cartoon bubble coming out of her mouth, saying “ I’m so scared. Mom’s been hurt. I don’t know why. What shall I do?” She described her own experience of fear and her experience of fear for her mother as interconnected and shared.

Sergei, born and raised in St. Petersburg in the Soviet Union, talked about his experience of pain as a Jew, a member of a group which was discriminated against in the USSR. Toward the end of the interview, while discussing his second Map, Sergei commented on the scene he depicted of being beaten up in a boy’s bathroom at school because of something he said about another boy’s girlfriend. Sergei went on to say, “ People do bad things. There are some bad people out there. I was not ostracized, but there is a Communist-Jewish issue [in the USSR]. [People] actively do things, illogical crud, ideology is used a lot in Russia now....People turn each other in.”

Bianca, who was born and raised in Queens, New York, chose to write about her experience of pain when her grandmother died, describing it as “shared pain”. She explained the complex relations involved in this shared pain, saying that she shared her father’s pain at losing his mother, “I felt bad about how my father felt. It was hard to watch my parent being upset.”

Jack, who was born in Monterey, California and raised in San Francisco, also talked about an experience of shared pain related to a death in his family. He explained that his grandfather's death was a painful experience for him. However, he was asked to speak for his generation at the funeral. As Jack put it, "There was shock and pain, then relief. The pain wasn't there. In the pulpit, I felt relief, the pain had lifted." Jack explained that, in sharing his experience of pain, he experienced relief from the pain.

In addition, Jack talked about other experiences of shared pain during his interview. Although he did not choose them for his Narratives or Maps, he talked about these experiences at some length during his interview. At the beginning of the interview, when he was asked to name some experiences of pain in his life, Jack said that two experiences of emotional pain came to his mind immediately. One was his experience of visiting Birkenau in Poland in 1997. As Jack explained,

I dealt with the idea of pain more with empathy and connection to the people there and what they suffered. I left an apple I was carrying. I set it in a wood shelter where people slept. The idea was to give something to people to whom not much was given except pain and suffering.

GENDER DIFFERENCES IN THE CONSTRUCTION OF PAIN

Women and men were not similar in all ways. There were differences between women and men in the content of the major themes they discussed. Gender emerged as an important factor in the ways in which people constructed their experiences of pain. First, perhaps not surprisingly, men reported that they

were not likely to talk to others about their pain. Conversely female participants not only said that they were comfortable talking to others about their experiences of pain, but also emphasized how important talking to others about their experiences of pain was to them. Second, a related finding, male participants explained that they were only likely to talk to others about their experiences of pain if they thought it was necessary because their ability to perform was likely to be affected. Third, male participants talked more about being worried about pain. Fourth, men talked about a structured group of associations, a sort of syndrome, consisting of "body aches", "body pain, muscular and joint pain", "pain resulting from a lack of exercise", "frustration" and "anxiety", while none of the women participants discussed such a complex of issues. Some of the male participants reported that this complex of issues was connected to associating pain with being indoors and feeling good with being outdoors, although this was not a topic which a sufficient number of male participants mentioned to allow it to be included as a theme. Fifth, female participants seemed to be more comfortable talking about experiences of emotional pain and about the relations between their experiences of physical and emotional pain. Conversely, male participants were more likely to try to avoid talking about experiences of more emotional pain and tended to be less comfortable discussing experiences of mental and emotional pain. Sixth, some female participants talked about pain related to their menstrual periods, with some female participants saying that they thought they were responsible for this experience of pain. Female participants also tended to emphasize their difficulties in obtaining help from medical practitioners with this

experience of pain. Seventh, female participants were more likely than male participants to talk specifically about two types of pain, chest pain and back pain. Female participants talked about chest pain in a different way than male participants, who mentioned tension in their chests as part of the “syndrome”. Also, three female participants made a point of talking about back pain, which no male participants did. Eighth, women were more likely than men to describe experiences of pain taking over their entire being and to describe experiences of pain in terms of their effects on specific body parts.

First, male participants emphasized that they were not likely to talk to others about their experiences of pain, and were even less likely to initiate conversations on the topic of pain. Conversely female participants tended to emphasize the importance of talking to others about their experiences of pain.

Male participants reported that they were unlikely to initiate a conversation on the topic of pain. Men reported that they might talk about pain if they were in severe pain, although they emphasized that, even then, it was unlikely they would initiate such a conversation. Most male participants emphasized that, should it prove necessary to discuss experiences of pain, as Kawika phrased it, “A brief conversation does the job.” For example, asked if he talked to other people about his experiences of pain, Bob replied, “ Not really”. He went on to explain, “Generally, I don’t talk about it a lot. A girlfriend once said that I never complained. I only talk about pain if it is extreme. If someone sees me in pain, I’ll

talk about it.” He added, “It’s only pain if it’s severe”. On the subject of initiating discussions of pain, Bob went on to explain, “ I wouldn’t seek out someone to talk about it or to help”. He emphasized, “ I would not call people.”

Finn’s comments offer an excellent illustration of male participants’ reluctance to talk about experiences of pain with others. He explained,

Talk to other people about pain? Hmm, no. I’m not in pain very often. Maybe, if I feel sick or have the flu. No, even then-really. About three or four years ago my roommate and I both had really bad flu. We couldn’t leave our rooms. Our eyeballs hurt. We got up and met in the communicating room for less than an hour, tried some soup. The way we talked about it was to joke. It was sooo bad.

Finn emphasized that if a situation was extremely painful, “This is really bad. I have friends I can call. They would be sensitive and commiserate with me. But, it would have to be pretty bad.”

In this quote, Finn portrays the way he and his roommate talked about their pain in terms of joking. Finn also explained that he did talk to other people about his experiences of burning his hands and falling while skate boarding, the subjects of his first Narrative and second Map. However, he emphasized that this was more a matter of telling stories, which he characterized as “war stories”, about these experiences than of confiding in other people, saying,

Even though I was embarrassed, I had words. They were sort of “war stories”. I told the story of how badly I wiped out. The fire became a big story for a while. My hands were in bad shape. Friends told friends.

Concerning talking with other people about his experiences of pain, Sergei said,

I try to tough it out. My wife says, "Talk to me."
 Sometimes I talk about emotional pain with other
 people. Usually, I don't. With my wife, I'm very close.
 She talks more. I talk to my wife. She makes me do
 it, nags me. I feel it burdens others.

Sergei went on to explain that he talks about mental pain only with his wife, but if he experiences physical pain, he talks to his mother. Kawika also commented that his wife often accuses him of not being sympathetic or of not caring enough. He explained that this is a problem because he thinks he tries to be helpful, but he is not really sure about how to deal with people who are experiencing pain.

Even male participants who seemed somewhat more comfortable in discussing emotions, such as Luke, expressed similar feelings about talking to other people about experiences of pain. On the subject of talking to others about experiences of pain, Luke explained,

Usually not. Only if someone brings it up. Not 100%.
 I might only bring it up if I was in severe pain or had
 such a severe headache. Then, if I mentioned it to
 whoever, I would generally apologize-that I was not
 understanding what they were saying [because of the
 headache] not processing information. I would talk
 about it to excuse my behavior, not to ask for help.

When Luke does talk to other people about pain, he speaks to "Generally, very close friends, people I trust, who are very close to me." He went on to say that, similar to Sergei, he generally picks the people he talks to based on the type of pain. Only one female participant, Jan, also mentioned using a similar selection strategy. However, her choice was affected more by how often, and how recently, she had contacted the few people on whom she relies. She

explained that she doesn't want the people on whom she relies to feel burdened, and, therefore, carefully monitors how much time and attention she is demanding from whom. However, she also described talking to others about experiences of pain as important to her.

Alasdair said that he does talk to other people about experiences of pain, but immediately went on to explain,

In general, I don't think people are very interested in hearing about your pain. Good news, accomplishments-but pain is not a frequent topic. If painful subjects come up, like with my family, I might describe the painful situation, but not use the word 'pain'.

Finally, although all the interviews were fairly long, the interviews with the men tended to be longer than those with the women. It seems possible that men, who do not appear to discuss their experiences of pain in the course of daily life with others, welcomed the opportunity to talk about pain in a what they might have viewed as a "safe" setting.

On the other hand, female participants not only depicted themselves as being very comfortable talking to others about their experiences of pain, but many female participants emphasized how important talking to others about their experiences of pain was to them. Many female participants reported talking about experiences of pain frequently with several people on whom they depended. Talking with others seemed to provide women in this study with help in dealing with pain and with information about other's experiences and possible treatments.

For example, Sooty said that she talks with “girlfriends, in general” about experiences of pain. She went on to explain, “They are very caring, even when they make jokes, it is in a very loving way. If I’m really stressed, they’ll joke to cheer me up, make me feel better. They would never say, ‘be quiet’”. Sooty’s example of her girlfriends’ use of joking to express empathy and closeness stands in sharp contrast to Finn’s description of his and his roommate’s use of joking to avoid talking directly about pain.

Cathy also explained that talking to other people about her experiences of pain was very important to her. She said that talking to other people helped her both to handle experiences of pain and to get information. She mentioned a number of people in her life with whom she talks about experiences of pain regularly, most of them female. As she put it, “I talk to my friends, my mom, my brother and my cousin about my experiences of pain”. She also said that she has two close friends in the US and three or four close friends who are still living in Hong Kong to whom she speaks about experiences of pain. She reported that she also talks to her father, although she is less likely to talk to him. She said that it is more likely that she will talk to her mother and that her mother will tell her father. She also talks to her husband, as she put it, “I tell him everything, almost.” Cathy explained, “These people will all discuss it [pain] with me”. She said that they are likely to tell her to see a doctor, which she is unlikely to do, but that they also are likely to tell her whether they have had similar experiences. They also take care of her, offering her tea and medication, if this seems to be called for. As Cathy put it, “They will get me anything I want, if they can do it.”

Cathy said that she talks to several female friends and a young aunt who also experiences pain related to their menstrual periods as a major part of the way she deals with pain related to her period.

Bianca explained that she talks to family and friends about her experiences of pain and that they are “a huge source of support and pleasure for me, the people who are consistently there when I feel pain.” She said that these people listen to her, and are “very supportive”, helpful and understanding. They are “there” for her. Similar to Cathy, for physical pain, they are more likely to suggest that she go to the doctor, while for more emotional pain, they are more likely to tell her that they have been through something similar and understand how she feels. They are all willing to spend time with her. Bianca also said that talking to other people about her experiences of pain actually helps to strengthen her relationships with people who are important to her in her life. As Bianca said, “I guess because a lot involves people. If I experience pain, I call on family and friends to help. It affects relationships. Mostly it strengthens these relationships.”

Even women who placed less emphasis on how important talking to others about their experiences of pain was in their lives, reported that they frequently talk to others about pain. They said that they feel comfortable talking to others about pain and find it helpful. For example, Zum initially said that she did not talk much to others about pain, adding, “But, not to describe it. It’s part of something that I did when I was doing my MA. People try to express pain informally.” However, Zum went on to explain, “I talked to friends and my friend’s

aunt about my cramps.... She said they will go away after the second child.”

Zum went on to say, “ It [talking about painful experiences] is part of friendship with a person.”

Although Georgina described herself as someone who tries to forget about pain or joke about it., she also said that she is willing to talk with others about pain and finds it helpful. She explained that she tries not to think about pain, saying, “ I have an athletic background. I run every day, from twelve to twenty kilometers. I had to forget the pain to run long distances.” and “Long distance running, like running a marathon, is painful.” She also said that joking helps her take her mind off pain, as she put it,

It [pain] is meant always as a joke. Joking is a way to deal with pain. When you joke, you take your mind off the subject. If you think of pain, feeling the experience of pain makes you uncomfortable. The mind is very powerful.

Georgina summarized the ways she deals with pain, saying, “I don’t like to think about pain. I joke about my own experience, but not others’. I distract myself, think about and do something else. Pain, you ignore and go on.” However, Georgina also described herself as being willing to talk to other people about pain and as someone who finds talking to others about pain helpful. As Georgina put it, “Sometimes, if I’m frustrated, it’s a way of trying to solve it, see another perspective.”

Second, male participants were more likely to be concerned about how pain affected their abilities to perform adequately

Men reported that they were most likely to talk to other people about pain when their abilities to perform were affected by pain. Male participants emphasized that they felt they had to talk about their experiences of pain because the disruption in their abilities to perform adequately was likely to affect others. Men said that, at such times, they would be likely to explain to the person or people who were immediately affected by this change in performance why their behavior might seem a little different. For example, as quoted earlier, when asked whether he talks to other people about his experiences of pain, Luke explained that if, for example, he had a headache, he might not be processing what the other person was saying very well, and, as a result, not understanding what that person was saying. In such a case, he said that he would mention the pain to excuse his behavior, not to ask for help. He repeated that, with headaches, his pain would be likely to be “major”.

Talking about his second Narrative, Bob said that, after running into a pole on a basketball court, “I counted and did some simple arithmetic in my head to make sure I could still think properly. I think I also ran through the names of some presidents and state capitals.”

Kawika explained that, if he did talk to others about his experiences of pain, it would be “Just the person immediately affected by my pain. For example, with this stomach ache, I told my wife I was not 100%. I told the cross country coach and my teammates to explain how I was running.” However, Kawika seemed to be reluctant to admit that an experience even qualified as “pain”. For example, Kawika distinguished between what he referred to as “discomfort” and “

pain". At the beginning of the interview, when he was asked to mention some experiences of pain, Kawika named five experiences: 1) his recent sickness, with stomach pains, which he qualified as pain, saying it "interfered with daily life", 2) a sports injury to his foot, 3) a sports injury to his knee, 4) pain experienced in connection with martial arts activities, which he did not feel qualified as pain, saying " But, this was discomfort, not pain, and 5) "running related", of which he also, immediately, said, "But this, too, was discomfort, not pain." This is similar to Bob's comment, "It's only pain if it's severe."

Third, men tended to report worrying more about pain

Worry was a theme that appeared more frequently in the interviews with male participants than with female participants. Sometimes, male participants' worrying seemed to be associated with fears of diminished performance.

Worrying about pain on the part of male participants was also associated with concerns with monitoring symptoms and wanting to know the cause of the pain.

In his first narrative, Bob chose to write about the leg cramps he sometimes gets when lying in bed. He commented on his narrative, saying,

Worry. I will be sitting in a theater. I feel a little twinge. I'm not even sure I'm feeling it. I worry about how I'm going to jump up and where I'm going to run to. There was one concert where I did have to get up and go somewhere. The cramp never hit, but I could feel it getting closer and closer. Whenever I sat for a long time, rather than enjoying what I was doing, I'll [sic] sit on the couch and get really nervous. Even if it is not really bad. The cramp is scaring me.

Bob also talked about worry in regard to the experience of pain he wrote about in his second Narrative. In this Narrative, he talked about his experience of running into a pole on a basketball court after school. He said,

I sat on the ground. I was worried, curious, not about the pain, but that all of a sudden, I was going to be stupid.

As quoted above, Bob went on to explain that he had counted and performed some simple arithmetic in his head to make sure that he still could think properly.

For his second Narrative, Sergei chose to write about the worry caused by his experience of “muscle pain”. Sergei explained this pain in his finger, saying, “It can occur anywhere. It’s happened in the college once or twice, at home once or twice, even visiting someone. It’s sudden. It recurs, the most recent was a couple of months ago”. He added,

It’s very somatic. The vascular part of my finger joint starts aching. It feels like an obstruction in the blood vessel. I rub it and it goes away after a while. It happens to my big, or ring, finger on my left hand.

Sergei said that when he experiences this pain in his finger, he does two things, rub it and worry. First, he said that he rubs it, because, “It seems like the right thing to do”. He went on to explain that he thinks his finger tends to be a little swollen, so he thinks that rubbing helps to “smooth the blood out” and “warms it up a bit”. Sergei said that the other thing he does about this type of pain is to worry because he doesn’t know why this happens to him.

I worry. If I don’t do this (referring to rubbing it) what will happen to me? I get worried there’s something in my blood that clots, like thrombosis.

Asked how he felt about this experience, Sergei went on to explain more about worrying,

A little worried. It feels vascular. Where else will it go? Will it go to my brain? My heart? When it goes away, it's like new. No way to check." [explaining why it would not make sense to go to a doctor] "It goes away, what would I say to a doctor? He'll say, "Go home.", since it hasn't developed more and it goes away.

Sergei went on to explain that, if a person falls from a tree, the topic of his first Narrative, he expects some damage and, as a result, expects some pain. Even if the pain is significant, the person expects it. However, Sergei said that he finds the second experience of pain more troubling and worrisome because it is a sudden pain and there doesn't seem to be anything that he can identify as its cause.

Kawika explained that he worries about the stomach aches he has had recently. He said that the stomach aches made him think back over previous experiences of pain, saying, "It's funny. I didn't mention this, but I had stomach pain a couple of years ago." He went on to say that the previous experience of pain had not been as bad, nor had it lasted as long. Because of these two factors, he didn't worry as much.

On the other hand, female participants said very little about worrying about pain. It is possible that this is because women appear to talk to others more about experiences of pain. As female participants in this study reported, talking with others about pain provided them with information about other people's experiences with similar types of pain and possible treatments, as well as helping them deal with the pain.

Fourth, men talked about an interrelated complex of issues, a sort of syndrome, consisting of various combinations of “body aches”, “body pain, muscular and joint pain”, “pain resulting from a lack of exercise”, “frustration” and “anxiety”

Male participants talked about an interrelated group of issues, involving body aches, muscle aches, body pain, frustration and anxiety, which seemed to constitute a “syndrome”. A syndrome is defined as “a group of signs or symptoms that occur together and characterize a particular abnormality” or “a set of recurrent things (as emotions or actions) that usually form an identifiable pattern” (Webster’s Ninth New Collegiate Dictionary, 1990, p.1197). This finding is especially interesting because the male participants who talked about this group of symptoms came from widely divergent backgrounds. For example, Luke, the thirty-one year old man from Brazil, reported that he experiences “body aches and muscular and joint pain”. He said that this “makes me feel frustration”. Luke said that he knows that the muscle and joint pain are clear reminders of his lack of physical activity and “my lack of drive to go out there and do it”. He added, “This generally makes me have a defeated attitude”. He summed this up, saying, “I know the story behind these body aches.”, although he said that he doesn’t know the story behind his headaches. This story seemed to be one of lack of physical exercise coupled with lack of drive and ambition.

Kawika, the twenty-nine year old raised largely in Japan, said that sometimes the muscles all over his body ache if he sits too long, either at work or

at home. He said that this had begun to occur in the last few months. He went on to explain that he tries to deal with it by trying to find a distraction, which, he added, is how he generally tries to deal with pain. Kawika went on to say that, in general, he tries to deal with body pain by working out. Kawika also linked his bodily experience to “frustration coming from overall life experience”, saying that a very significant aspect of pain for him was “very different”, a “sort of existential pain”, which he described as being very hard to define, but of which he said, “It feels almost like frustration.”

Sergei, the thirty-five year old man born and raised in St. Petersburg, USSR, also said that he experiences “muscle pain” if he doesn’t exercise regularly. He said that the muscle pain he experiences in his back is severe enough so that he finds it “hard to walk straight”. He went on to say that, on the other hand, after he has exercised, even if he experiences pain, whichever muscles hurt, “It’s ‘good pain’, because it makes me feel like I have done something.”

Jack, the thirty-three year old man who was born and raised in Monterey and San Francisco, presented the richest, most complex description of this combination of experiences involving pain, frustration and anxiety while discussing his “ongoing, daily pain” saying, “It’s part of the human experience. I have an average daily level of anxiety, pain and frustration - a pretty average experience, I think”. Jack went on to say that, when he was completing the Consent Form and saw what the study was about, “I immediately thought of breakdown, sobbing, a physical pulling on my chest area because of the release

of emotional tension and stored emotional trauma”. Jack went on to talk about his experience of “anxiety and depression” saying that it is

a feeling in the chest. It feels like swirls of tension. And (He pointed to his chest while saying this) the energy feels bottled. When I exercise, it's as if I free my body to let go of that-to unwind coils of anxiety, not immediately, but in the long run, it helps. The mind-body connection is so important. I'm sensitive to the physical. When I don't do it [physical activity], my mental image of my body pulls into my self. When I exercise, I don't feel the need to pull away from the world. Depression might be physical, one isn't engaged with life, not doing anything. It is important to exert oneself 100% or I feel inhibited physically. It is a process of forcing my self to go to the gym or run in the park. You have to force yourself to break out of a cycle of trapped forces, force yourself to be active.

Jack, like Luke, Kawika and Sergei, describes feelings of tension and anxiety which are released when he exercises. He emphasizes how important physical activity is to his mental image of himself and his ability to engage with the world. He depicts inactivity in terms of swirls of tension and bottled energy which need to be released by physical activity and exercise.

None of the female participants in this study described such a complex of issues, not even female participants who said that sports were important to them. The closest any of the women came to this theme was Bianca, who said that she was very upset by a recent injury to her foot, an experience she chose to write about in her second Narrative. Bianca explained that she was disturbed about hurting her foot, and even tried to ignore that it might be injured severely enough to require the attention of a doctor, for two main reasons. One reason was that she felt that she was too young, she was thirty at the time of the interview, to

have to deal with an injury like this. The other reason she gave is that she uses exercise, especially running, as an emotional release. Since this foot injury, she has not been able to rely on exercise for emotional release, as she is used to doing. However, Bianca did not describe this complex of issues which the men talked about. In addition, Georgina, who described her athletic background saying that she went to a “special” high school in her native Hungary which emphasized sports and reported that she still runs twelve to twenty kilometers every day, did not talk about this complex of issues which the men raised.

Men in this study seemed to link their experiences of muscle, joint and body pain to inactivity. Moreover, the feelings they expressed about this inactivity being related to their images of themselves as active and effective people, served to connect their experiences of muscle and body pain to feelings of personal inadequacy and ineffectualness. For these men, active engagement with the world and physical exercise seemed to be necessary for them to maintain a positive sense of self and feel able to engage with the world. They appeared to feel frustration and anxiety when sensations of body pain occur because they experience this pain as personal inadequacy due to inactivity and failure to be productive. These men appear to use physical exercise and working out to make them feel effectual and competent and to relieve feelings of tension and being defeated.

The syndrome which the male participants described will be analyzed in greater depth in the following chapter which deals with in-depth analyses of the interviews with five participants. In this chapter, Jack’s description of this

complex of issues is analyzed in the context of the comments he made in his interview as a whole. The theoretical implications of this syndrome will be discussed further in the Discussion chapter.

Fifth, Women appeared to be much more comfortable about discussing emotional or mental experiences of pain and the relations between physical and emotional pain. Conversely, men were much more likely to try to avoid talking about mental or emotional pain and reported being less comfortable discussing mental and emotional pain

While all the participants eventually discussed both physical and emotional experiences of pain, female participants often seemed to be eager to explore their experiences of emotional or mental pain, while male participants often expressed discomfort about talking about emotional or mental pain. Men sometimes even explicitly stated that they could think of an experience of more emotional pain, but were deliberately going to pick a more physical experience of pain to talk about. Anya was one of several female participants who talked at some length about the relation between physical and mental or emotional pain. Like other female participants, Anya was not only willing to talk about more emotional types of pain, but was eager to explore the relationships between physical and emotional experiences of pain. As she began to write her second Narrative, Anya said,

I'll do emotional so you'll have different kinds. It will be interesting to see how they're different or not. I'm going to give more thought to the different kinds of pain in my life.

Discussing her second Drawing, in which she depicted her mother beating her, Anya commented that this was “physical, but more emotional”. She went on to say,

It was scary. Back pain [about which she wrote in her first Narrative] wasn't scary. It seems like I have more control over back pain. I felt very out of control over this more emotional experience of pain, But not as frustrated or irritated. I can use it, unlike physical pain, “healthily”. Pain is not all negative. It can help in learning.

Reflecting back toward the end of the interview, Anya talked more about relations between physical and emotional pain and about how this experience of emotional pain had helped her learn, saying,

There's a learning aspect-emotional or physical-this second map-my interaction. There is physical-emotional exchange. It makes me think about how I'll be as a parent myself. How to raise children well. What is the standard of a well raised child?

Zum also displayed an interest in exploring the relations between physical and mental pain. She chose to talk about the relations between physical and emotional pain several times over the course of her interview. Early in the interview, when naming some experiences of pain in her life, Zum talked about her experience of her grandmother's death, saying, “When my grandmother died, I felt sick. It affected my whole system: emotional, physical, both. Sadness causes pain.” Later in the interview, Zum described experiences of physical pain as sometimes taking over her whole world, saying, “ My perception is not open to other stuff”. She went on to explain that, “ It is the same way with emotional pain,

like grief.....When the pain lessens, it seems like you open your senses, to the outside.”

Zum also described an experience in which she used the relations between physical and mental or emotional pain to help her deal with emotional distress. As she described it , “A couple of years ago, I was sad, felt guilty. The only way to get rid of ‘thoughts’ was to put a scratch on my wrist. I was an undergrad. I used a metal cutter. I replaced emotional pain with physical.” Since this seemed like a rather startling thing to do and I became somewhat concerned, I took the opportunity, in the closing section of the interview, to ask Zum more about what she said she had done. Zum explained, saying,

It’s part of a continuum, physical to emotional. Physical pain and emotional pain are interchangeable. I used to think this was silly. Now-our culture is Cartesian. The self is a scale. Try, when you’re in trouble, try to move into a different system. The scratches, four or five years ago, I heard about this from other people. You can play around with the scale, from thoughts to physical pain.

Olivia, like Zum, said she thought physical and emotional pain are connected. As she put it, “Everything [is affected] in pain. The psyche is affected. Physical, emotional, the whole day. The way you look at life. Physical pain is not healthy. If you don’t have pain, you don’t have anything. Emotional pain can mess up relationships.” Like Anya, Olivia also comments on opportunities for growth and learning made possible by pain when she says, “If you don’t have pain, you don’t have anything.”

Olivia also talked about how important her emotions regarding pain are to her. This creates a difficult situation for her, because, as she says,

I feel I have to deny my emotions...Then you're not strong, you're weak... I tend to cry a lot. I feel very sensitive. I was always told, 'Don't be so sensitive.' I think it's ridiculous...Yes, I like to deal with my emotions. I feel it's necessary or it would be more destructive...

Olivia said that she found denying her painful emotions difficult.

On the other hand, several male participants explicitly stated that they thought of emotional experiences of pain, but deliberately decided to avoid talking about these more emotional experiences. A lengthy presentation has already been made of the interviews with Kawika, Finn and Bob, in which they themselves stated or eventually realized that they tried to stick to the subject of physical pain and avoid talking about emotional or mental pain.

Sergei also stated that he was not going to talk about emotional pain because it made him more uncomfortable than talking about physical pain. While trying to think of a scene to depict for his first Map, Sergei said, "What do I recall from this age?.....Getting hit in the mouth, that would be more fun to talk about. I also remember being spanked by my mother. That's too psychological. I'll talk about getting hit in the mouth." Thinking about a subject for his second Drawing, Sergei said, "There was more moral pain, just joking. It does count [as pain]. So far I've concentrated on physical pain." However, he proceeded to select an experience in which he was beaten up by another boy saying that this was more physical pain.

While Luke, who was one of the male participants who seemed more comfortable in dealing with emotionally oriented experience of pain, was trying to think of an experience of pain which occurred when he was ages twelve through

seventeen for his second Drawing, he paused for a rather long time. He then said, "Twelve through seventeen? Hmmm." , followed by another rather long pause. He went on to explain, "I can't remember. I'm trying to get out of the emotional stuff. I can't think of anything other than emotional stuff from adolescence". Taking up a green pencil, Luke proceeded to portray an experience which took place in a gym class in which he felt he was unable to keep up with the other boys, saying, "Workouts at school were physically painful." However, like Kawika, Finn and Bob, Luke found himself discussing an experience which had both physical and emotional components. As Luke said, "We had to run for PE (physical education) class, run a few times around [the track]. I was pretty overweight- really fat. I remember it was physically painful-as well as mentally.." During the Life Stories Interview, Luke reflected back on his second Drawing, saying, "For adolescence, I didn't want to go for the emotional....It was a minor emotion. I felt horrible...but it was physically painful. Very military like."

Paris, while thinking of a topic for his second Drawing, brought up several more emotionally oriented experiences, then mentioned some more physical experiences of pain and finally refused to draw his second Map. He began by saying that he had not had injuries of any kind during this period of his life, when he was ages twelve through seventeen. As he put it, focusing on physical pain, "No broken bones". He moved into a more emotional realm when he explained that he was the first male cheerleader at his high school and "I was a popular kid, easy to get along with". He said that he recalled few incidents of pain,

proceeding to list only three experiences of physical pain: cutting his knee when he was about twenty-six to twenty-seven, falling on a piece of glass, and having a toothache when he was around twenty-one or twenty-two. After constructing this ad hoc list, he concluded that he had not had any experiences of physical pain when he was ages twelve through seventeen. However, he went on to say, “I felt I was the only gay man on the planet... It was hard to date because I was gay. I didn’t date. I was doing other things.” Having mentioned this more emotionally oriented experience of pain, Paris declined to make the second Drawing. In the Life Story section of the interview, Paris did return to discussing some of these more emotionally oriented experiences, without appearing to realize that he had returned to talking about more emotional experiences of pain, but he tried to keep his comments on these topics to a minimum.

Sixth, female participants talked about pain related to their menstrual periods. In addition, some female participants said that they thought that they were responsible for the pain they experienced related to their periods. Female participants also discussed their difficulties in getting help from medical practitioners.

Five of the eleven female participants (45%) talked about their experiences of pain related to their menstrual periods. Sooty, who talked about physical pain only when specifically asked, replied that she could think of only two experiences of physical pain: chest pain and menstrual pain, about which she said, “physical pain, the biggest is my period-pain from my period”. Sooty

did not choose either of these forms of physical pain as subjects for either of her Narratives or Maps. However, in the Life Story Interview portion of the overall interview, Sooty talked a great deal about her experience of pain related to her menstrual period. She explained that because the biggest physical pain she experiences is that related to her periods, she has seen “lots of specialists”. She illustrated the severity of this experience of pain, saying, “At work, sometimes I have to leave. I don’t want to faint at work.”

Like some of the other female participants who experience pain related to their menstrual periods, Sooty explained that she found it difficult to obtain adequate help from medical professionals. Her comments on these difficulties constituted a large portion of her discussion of her pain related to her periods .

She said,

The doctors perform so many tests but they don’t do thing. So many tests. They say that it is a very mild version of endometriosis. But, there is nothing to do but take birth control pills...If this is mild, my God!

Regarding this treatment, Sooty said,

It helps very little. I still have pain. I have shorter periods, but I don’t feel good, generally. Also, the birth control pills make me tend to put on weight, make me depressed and moody. You trade one pain for another.... I went to the doctor. He was awful. Last year, it got really bad. I was having two periods a month. The doctor was an old man. He said, ‘What do you expect? You’re a woman. It’s normal. It’s something women have to put up with. It’s part of life.’ They can’t find anything, so they act as if you’re sort of making it up. He wrote a prescription for a drug, about like Advil. That was it. I was shocked!

Sooty subsequently went to see two other specialists, of whom she said, “ They were much nicer. They did ultrasounds, Pap smears. They said it wasn’t operable. The end result. I took birth control pills. It’s the only treatment.” Finally, Sooty explained, “ There was a financial issue for the doctor. You can get injections. But, they cost \$200 to \$300 and have to be repeated. Insurance doesn’t pay for that.” Sooty concluded, saying,

I felt disappointed. I felt like- a lot of women don’t experience pain. I’m one who does. I get really mad. In today’s modern world, how can they not do something? It’s a strange feeling. They’re not really understanding. They’ve heard it so many times, they don’t really hear you.

She also explained that she talks to all her friends about “period pain”, saying, “ I talk with my friends about this because I am so angry that I have to go through this.” She said that her friends sometimes say, “ It can’t be that bad”. However, Sooty said, “They don’t experience it. It disrupts my daily activities.”

Although Archis, like Sooty, did not choose the topic of pain related to her period as the subject for any of her Narratives or Drawings, at the beginning of the interview, she mentioned eight experiences of pain, the fourth of which was her experience of pain related to her period. Later in the interview, she explained that this condition had sent her to the emergency room, where she ran up such high bills that the people at the hospital suggested she apply for medicare (sic) in order to pay for her treatment. During the first part of the interview, where participants are asked for basic demographic information, Archis had mentioned that she had to apply for medicare (sic) in order to deal with extremely high

medical bills she had amassed, without specifying the condition which necessitated this treatment.

Archis explained that her condition was not diagnosed for some time. However, she learned about the probable cause from talking with friends and acquaintances. As she said,

“I found out about it on my own.” Similar to other female participants, Archis explained that she did not always have difficulties with her period, saying,

I didn't always have this problem. I had no problems [with menstruation]. It just started the last year of high school. I thought it was the flu. Because, I remember, I was at school. I had to register for the Caribbean-wide exams. I became cold, was shivering. I needed to throw up. Of course I didn't tell anybody it was that time of month. Flu-like symptoms. I was sent home from school.

She went on to explain more about how she learned from others about the condition of endometriosis,

I started college the following year...talked to classmates. They told me it was endometriosis. There was no way to deal with it, I heard. Eventually, I went to a doctor, who said to take the pill [birth control pill]. He didn't diagnose endometriosis.....But, I felt, well, I knew someone else who went through the same thing. It 's not rare. Odd. It's a queer thing. The person talked about it because she knew she had endometriosis.

Like Sooty, Archis seems to have resigned herself to just living with this condition, without expecting much help from the medical profession. As she put it, “I tolerate it, deal. Like the groin pain, I have to deal with it. You have to get through it and take care of yourself.”

Cathy chose to write about pain related to her menstrual periods for her second Narrative. She explained that she began to experience pain related to her periods when she was about eleven or twelve years old. She said that she sometimes takes medication for this type of pain, although she rarely takes medication for any other experience of pain. She also said that she sometimes goes to the doctor, although, in general, it is rare for her to consult a doctor about other conditions or experiences of pain. In addition, she sometimes takes a Chinese herbal supplement to help in dealing with pain related to her period, although she explained that she really considers this herbal supplement as more like a “healthy food” than a drug.

Cathy said that she does not feel that the pain related to her menstrual periods is important. However, she went on to say that, when she experiences this type of pain, she can’t work well and she is likely to deal with the pain by going to bed, and, possibly, sleeping. As Cathy explained,

How I feel is the most important, the most important thing is that I can’t work well. If I have an exam, I can’t do anything. Usually I sleep it away. I stay in bed, read relaxing material in bed. It’s really annoying.

Although Cathy’s comments on her experience of pain associated with her menstrual period show that this pain does interfere with her life to some extent, even sometimes causing her to take some medication, see a doctor or go to bed to “sleep it away”, for the most part, Cathy describes herself as carrying on with her life. In addition, Like Sooty and Archis, she uses talking to other people to help her deal with this type of pain. She talks to friends who also experience

pain from their periods and to a young aunt who is her father's sister. She said that they tell that, like her, they go to bed and try to sleep when they experience menstrual pain. In addition, she said these friends also talk to people and take herbal supplements. Her aunt recommends putting wine or beer on one's stomach and rubbing it into the skin. She said that she finds this pain very annoying and asks "Why me? Why wasn't I born a boy or a woman who does not have this pain?"

Cathy described her experience of asking her doctor for help in dealing with this pain in a more positive way than did Sooty and Archis, although her doctor also said there is little that can be done. She explained that her doctor said,

It's fine. It happens to some women. There is nothing else to do but take pain-killers when the pain is bad, rest at home, forget about it, take the Chinese herbal supplement.

Cathy concluded, speaking about her doctor, "Yes, she's real nice. She talks with me." Although Cathy's doctor did not offer help, Cathy seems to feel she was willing to talk with her and also offered reassurance that nothing was wrong.

Like Cathy, Zum chose to write her second Narrative about her experience of pain related to her period. In talking about her second Narrative, Zum described this pain as severe, saying, "For the last three to four years, I have had indescribable period cramps. Sometimes I feel like crying." Unlike Sooty, Archis and Cathy, Zum was one of the female participants who made strong statements indicating that she thinks that she is responsible for this experience of pain. As Zum said,

For the cramps, I blame myself. If I catch cold, don't keep myself warm enough. There's a reason for it. Myself..... It's usually my fault. Maybe the pain lasts longer because I don't take medication. I caused it, I deserve to suffer. Again, I did the same thing. I know better. Now, I deserve to suffer.

Olivia also said that she blames herself for her experience of pain related to her menstrual period. Although, like Sooty and Archis she did not choose this experience of pain for either of her Narratives or Maps, like them she chose to talk about this experience of pain toward the end of her interview. Olivia explained that not only does she think she is responsible for this experience of pain, but her perception that she is responsible affects the way she deals with it, saying,

Sure. Feeling that I'm responsible myself, I don't have the right to ask for help or the right to complain. If someone else is responsible, I have the right to complain....

Female participants who talked about experiencing pain associated with their menstrual periods emphasized that this pain was sometimes so severe that it disrupted their lives. Several women talked about difficulties in finding adequate help from medical professionals in dealing with this pain. Women said they were told that nothing could be done or to take birth control pills, which caused unwanted side effects. Two women reported that a doctor told them it was just a normal part of being a woman. Although one of these women, Cathy, appears comfortable with the care she is receiving from her doctor, the other, Sooty, explained that she is angry at the way medical professionals have dealt with her experience of menstrual pain. Finally, two female participants

emphasized that they thought they were responsible for this pain so didn't deserve help.

Seventh, female participants also talked specifically about two other kinds of pain, back pain and chest pain. The way women talked about chest pain was different from the way men discussed chest pain, which they mentioned as part of the “ syndrome”

Four of the eleven female participants (36%) mentioned experiencing chest pain. Sooty, who mentioned experiences of physical pain only when asked, naming only two, chest pain and pain related to her period, attributed this pain to stress, saying, “If I'm really stressed, I get chest pain.” Olivia mentioned “chest tension” as the fourth example of experiences of pain she has had in the course of life, although she did not choose this as a topic for her Narratives or Maps, nor did she talk about it in other portions of her interview.

Cathy chose to write her first Narrative about her experience of pain in her rib area. She described this pain saying, “

It's a sharp pain. It occurs very suddenly and lasts only a few minutes. But, it is very painful. I must breathe slowly because it is painful to breathe. I have not gone to the doctor to find out about it...The pain is really sharp and very sudden, kind of like being hit by a knife.

Cathy explained that she chose to write about this pain because, “ I think it is more interesting. Not many people experience it.” However, she added that her cousin also has this pain. She explained that they both began to experience this pain after coming to the United States, about two to three years previously. She

said she has not gone to the doctor about this pain because she is too busy, saying, “ If I am not working, I would rather stay home and relax. I seldom have time to stay home and relax.” Cathy also said that she dealt with this experience of pain by talking to people, including her husband, her cousin and her mom. She added, “I have considered that this might be related to stress. That is my cousin’s doctor’s opinion.”

Zum also chose to write her first Narrative about her experience of chest pain. However, Zum’s chest pain seems to be the result of jumping off a bridge about forty feet high just two or three weeks before the interview. She said that she did this because her friends did it and because she loves the water. However, she went on to explain that the situation was not quite that simple, she made the jump to try to deal with a fear of heights and because she was afraid that, if she didn’t jump, one of her friends would think badly of her, saying, “I went back and forth. I wanted to deal with a phobia about heights. Also, at the time I thought that a person who had recently done it would think badly of me.’ Afterwards, she had “ an incredible pain in my legs, then my chest”. However, she said, “ Overall, I felt good about doing it.” She explained that her friend’s brother, who had some medical training, but was not a doctor, said that he thought she might have hurt the tissues there. However, she did not go to a doctor, saying, “It was complicated.” She finally did go to a nurse, who said that it would get better eventually, which it did.

Since one woman experienced chest pain due to an injury and a two others did not elaborate on their experiences of chest pain, only one woman

provided extensive comments on her experiences of chest pain. However, it is interesting that these two women attributed their chest pain to “stress”, while a third woman characterized this experience as “chest tension”. Unlike the men, who talked about a related group of signs which appeared to comprise a sort of syndrome, the woman who elaborated on her chest pain talked about it in terms of discrete sensations, such as “sharp”, “sudden” and “like being hit by a knife”, which she did not appear to connect to her image of herself.

Only three of the eleven women (27%) talked about experiences of back pain and they offered very different reasons for their back pain. However, no male participants talked about back pain. There were two particularly intriguing aspects to women’s reports of back pain in this study. First, while none of the men in this study chose to talk about experiences of back pain, clearly, men also experience this type of pain. For example, Olivia said that her husband experiences the same form of back pain that she does. Based on the small sample of participants in this study, it is not possible to determine whether male participants in a larger sample would have chosen to talk about back pain. Second, although all participants were carefully screened in order to avoid recruiting participants who had any chronic pain problems, these female participants seemed to view their experiences of back pain as so much a part of their normal lives that they answered, during the phone conversation to screen out people with chronic or clinically significant pain, that they had no such problems. Since it is their subjective perception that they do not have “chronic” or “clinically significant” problems, but that their back pain is an intrinsic part of

their normal lives, these participants were included in the current study. Such a discrepancy between the medical view and people's "lived experience" of health and illness is frequently found in qualitative health research (S. Ouellette, personal communication, March, 2004).

Olivia chose to write about her experience of shoulder and back pain for her second Narrative. She explained that she experienced this type of pain mostly in her home. However, Olivia followed this immediately by saying, "It is constant. It goes where I go." She said that she experiences this pain "on a daily basis, starting about five years ago or so", when she was about twenty two years old.

Olivia said that her husband suffers from the same thing, which she identified as "sciatica", but that "he does nothing". In the Life Story section of the interview, Olivia said that she talks about this experience of pain, mostly to her husband. He tells her to "suck it up". She said that, like others in her life, "He doesn't like the fact that I cry a lot. He says, 'Don't cry about back pain, a bad back. I have pain, as well. I don't have time right now. Quit complaining.'" However, Olivia said that he is very concerned about her chest pain, a form of pain which he doesn't experience. He tells her to "avoid the hurt" and urges her to "use pain killers". She said that her husband seems concerned about her chest pain and her pain in dealing with her father. However, "he brushes off the back pain. He has it." She added that this is not the way she would like to be treated, saying, "I want to be pampered."

As she did with her menstrual pain, once again Olivia blames herself for this experience of pain. Concerning her back pain, Olivia said, "I am a tense person. I don't do yoga with stretches. I blame myself. I could do something." As with her chest pain, Olivia attributes her back pain to tension. Finally, Olivia said, "I feel physically high strung, tensed up. I need to control it. I blame myself a bit. I need to learn to deal with it." She elaborated further on her feeling that she is responsible for her experiences of pain, saying, "Usually, no one but myself [is responsible for my experiences of pain]. Although it depends on the situation." She added, similar to her comments on her experience of pain related to her periods, "Feeling responsible myself, I don't have the right. I am tempted not to ask for help or to complain."

Olivia said that she sees a massage therapist sometimes for her back pain. She explained, "He helps and-more- he really listens as I explain my problem. He also tells me the kind of stretches to do." Olivia also saw a doctor, as she explained, "She gave me muscle relaxers, but they were too strong." Her back pain has affected her life to some extent. Although she did not explicitly make a job change due to it, Olivia pointed out, "My neck and back are stiff. Now I don't have a desk job. But that's a minor reason." Olivia said that when she was in college she "had to take a physical education course. I took it and I realized that it helped. My body didn't feel really stressed." She went on to explain, "I recognize when I need to do yoga. But I'm lazy. I can't motivate myself. It has to be very easy for me not to avoid it." Although here Olivia seems to be connecting her back pain to not exercising properly, unlike the men who

discussed the syndrome, she does not connect her failure to exercise to her own self evaluation and perception of her ability to engage effectively with the world. Olivia also said, “ I stretch, ask my husband to massage it, or massage myself, that relieves it.” She added that a supportive mattress would help, but, “ We can’t afford it.” She said, “ I hate it. It’s not terrible. It’s annoying. I constantly think about it.”

Anya chose to write about her experience of back pain for her first Narrative. This was also the first experience of pain she mentioned at the beginning of the interview when she was asked to name some experiences of pain, when she explained, “It’s very persistent. It comes and goes. I’ve been getting chiropractic treatment for three or four years. I go every two to three weeks.” She said that she chose this topic for her first Narrative because “It’s the first thing that comes to mind. It’s always there-constant.”, although she had said earlier that “ it comes and goes”. She explained that this experience of pain occurs “ everywhere” adding, “It was diagnosed in grade school, but there was no pain-scoliosis. The pain began in high school.” when she was about sixteen years old and “I knew there was something way back when I was pretty small. All of the family has back pain.” Anya explained, “ I manage my life around it. I limit my time on the computer. I have ‘safe’ sleep positions. I exercise, when possible.” Similar to Olivia, Anya said, “I go to a chiropractor. My husband helps with massages.” Anya explained, “It makes me feel non-functional. It’s frustrating. I get cranky and upset, irritable. It affects my relations with other people.” She also explained that “ My mother had a lot of the similar symptoms-

all her life. We did a lot of talking together about how to manage back pain. She didn't get treatment. She thought it was a normal part of life.-back pain and no treatment or care. Now she does get treatment. It worsened and surgery is impossible."

Anya presented a complex picture regarding who she feels is responsible and the role talking to others plays in the way she handles this experience of pain. Although Anya did consider herself to be somewhat responsible for her back pain, she said that she thinks she has more responsibility for her interpersonal difficulties with her mother. Although Anya does find talking to others helpful, saying, "It helps not to keep it to yourself. I push myself to share, not just manage it by myself", she also said, "With the back pain and eczema, it's [talking's] no use. It's just a waste of time, a stupid, useless waste of time, energy and money. It's punishment. No freedom. They torture me. I can't find any use for myself or it." Anya also faces something of dilemma in talking to others about her experience of back pain, because, "I hate it when people feel sorry for me." and "with friends who get upset, I feel like a victim. That's not who I am in my own eyes.....Then I feel sorry for myself. It's not just control. It's dignity about myself.....I like to be treated with dignity, not pity." However, in general, Anya said, "Pain is sometimes helpful. It can make you learn and make choices..." She listed three sources for her experiences of pain: heredity for her experience of back pain; environmental factors "which create toxicity" for her eczema, and "personal" for her difficulties with her mother, saying "I am stubborn."

Back pain was a key issue In the interview with Jan. She mentioned back pain first when asked to name some experiences of pain and referred to her experiences of back pain frequently throughout the course of interview. In addition, she chose to write her first Narrative about her recent experience of back pain, saying, “It is very salient. It was very recent-very upsetting. It left me vigilant. I had a pretty severe reaction to having had it five years ago....I was so stunned that it happened again.” She explained that she was at home the first time it happened, five years previously and at work when it happened recently, several weeks before the interview. Like Olivia and Anya, the first time she experienced back pain, Jan eventually consulted a chiropractor, after staying in bed for five or six days. When it happened the second time, she went to the chiropractor immediately. Also similar to Anya, Jan said, “ My mother had back problems through the years.” However, unlike Anya, Jan said, “ They often came from overstrain, especially before significant events.” She proceeded to link this recent experience of back pain to an experience of back pain which had occurred five years previously. Jan explained this second experience of back pain saying, “ I felt out of control. I panicked. I was weeping from the pain. Physically, it was hard to breathe...also, emotionally, I was frightened. I thought I would never get better.....I felt ‘you are basically paralyzed’.” Jan explained further, “It would have been wonderful. I had just been promoted at work” and, due to the back pain, she described herself as saying she “felt I would never walk again.”

Two of these three women mention family histories of back pain. Both Anya and Jan say their mothers had back pain. All three women talk about back

pain as an ubiquitous part of their lives. They describe this experience of pain in terms of making them feel “non-functional”. They find back pain “frustrating” and “annoying” and it makes them feel that they have no control. They report that back pain interferes with their lives, although they strive to maintain normal routines.

Eighth, women were more likely than men to describe experiences of pain taking over their whole being and to describe experiences of pain in terms of their effects on specific body parts

Zum, for example, illustrated both these elements of women’s constructions when she depicted a scene in her second Map in which she had the mumps. Concerning this experience, she said, “It was the only thing I could think of. The only thing I remember is sickness, the mumps. I can draw my beautiful ear.” She described this experience solely in terms of one body part, her ear, saying, “I felt like I was an ear, aching.” She also described this experience as,

Encapsulated. A moment. One point in time and space...The ear begins your body. It is all you are conscious of. It emphasizes one center of consciousness of your body. Your body as a blob... When I have extreme pain, everything else goes away. I only focus on the pain. My perception is not open to other stuff.

Olivia focused on one body part, her face, in her description of an experience in which several family members took her riding in an open, rented convertible in Florida, a week before her sixteenth birthday. Olivia began her

description saying, “ I’m going to draw myself. Just my face.” She added what she referred to as “spots” on her mouth. She also added a lot of hair, saying, “My hair. It’s always a big feature.” She explained that she was looking forward to her sixteenth birthday very much. It was to be a special occasion. However, due to riding in the convertible for the entire day, in the sun and wind with the top down, as she put it, “ I developed blisters on my lips. Slabs on my lips. It was very painful.” As a result, at her sixteenth birthday celebration, “ I couldn’t smile for the pictures.” Like Zum with her ear, Olivia depicts her face, especially her lips, as the all consuming nexus of this painful experience.

In her first Map, Anya portrayed herself with her hands prominently displayed, sitting on her bed in her bedroom. She proceeded to depict her feet, also prominently featured, to this drawing. Her prominently displayed hands and feet were the focus of her construction of this experience. She explained that her hands and feet had been affected by severe eczema when she was between the ages of six and twelve. She said this had resulted in her hands remaining “ tough”, asking me to feel her hands in order to observe that they still seemed “tougher” than normal and saying, “Oh, eczema. It was painful. I forgot all about it. Feel my hands. Aren’t they tough?” Interestingly, Anya explained that this condition was not unusual and, therefore, not stigmatizing, where she was born and raised, in Prague in the Czech Republic. On the contrary, she reported that eczema was a condition from which many children of this age suffered at that time, as a result of pollution under the Soviet regime. As Anya explained, “Back then, it mattered, but not terribly because it was so common. It was not unusual.”

Finally, Jan depicted herself in her first Map as a star-like point of pain. There is no indication of her actual, physical body. Only the star-like point of pain is illustrated, which seems to have absorbed all experience of her body. Jan explained that she had drawn an experience in which she hit her knee on the edge of a stage while running, resulting in a very painful injury. No male participants portrayed any of their experiences of pain in this manner.

Some gender related issues were suggested by the responses of one female participant, Cathy, but did not merit inclusion as themes because only one participant raised them

Cathy raised some intriguing issues regarding gender, status and power. During her interview, Cathy emphasized how important it was to her to show “I can take it” and not to cry in front of other people. She explained that, now that she is an adult, she will cry in front of her husband if she experiences pain, saying this is partly because he is almost always there. However, she said that, beyond his usually being present, “It is OK to cry in front of your husband” since a woman is supposed to be weaker than a man. However, she also pointed out that this was not the case with her younger brother when they were children growing up. Because she was the older sibling, she was supposed to be the stronger one. Therefore, she felt that she could not cry in front of her brother. At some point while they were growing up, his being a male overtook, or became more salient than, his being younger. She described the current situation, now that they are both adults, as something of a mixture. Now her younger brother

won't cry in front of her because he considers himself to be stronger since he is an adult male. Nevertheless, she said that she still won't cry in front of him, even if he does consider himself the stronger of the two, because she is still the older sibling. As Cathy phrased it, "For the older ones in the family, there is a hierarchy of power. Being the oldest really matters. Also, I am the favorite child of my Dad, because I came first. When you enter first, you are the main one."

The themes related to gender, status and power which Cathy raised will be explored in greater depth in the following chapter, where Cathy's development of these themes over the course of her entire interview will be examined. It seems possible that Cathy's concern about crying in front of her younger brother is related to Olivia's discussion of the pressure she experiences to "deny my emotions" and not to cry, because this will be interpreted as a sign of weakness. Because this issue did not emerge strongly enough or with sufficient frequency in this overall content analysis of the interviews, it was not included as a theme in this chapter. However, in the following chapters, issues of gender, status and power will be investigated further from the perspectives afforded by the other methods and analyses used in this study.

What information is provided by this method and analysis to answer the research questions?

This chapter provides information which addresses the first research question: In what ways are men's and women's constructions of pain

similar and different? and the third research question: What do men and women do to deal with pain?

This analysis revealed six similarities between women and men. First, both women and men displayed awareness that in our culture, largely due to the prevalence of the biomedical model, physical and emotional pain are viewed as separate entities. Second, both women and men chose to talk about a wide variety of types of experiences of pain. However, third, neither female nor male participants were able to maintain this distinction between physical and emotional pain through the entire course of their interviews. Fourth, not only were participants unable to limit their descriptions of pain to physical pain, but both female and male participants connected pain to many aspects of their lives. Fifth, for both female and male participants, it appeared that the way in which their families dealt with pain as they were growing up influenced the ways they themselves dealt with pain as adults, regardless of differences between families in the ways pain was handled. Sixth, both female and male participants talked about experiences of “collective” and “shared” pain. Neither women nor men limited their descriptions of pain only to personal, individual, self contained experiences.

This analysis also revealed differences between women and men in their constructions of pain. Male participants’ described a sort of “syndrome” consisting of muscle, joint and body pain, concerns about not being physically active enough, frustration, anxiety and depression. It appears that men connect issues of self esteem to their images of themselves as active and effective

people. For these men, active engagement with the world and physical exercise seemed to be necessary for them to maintain a positive sense of self and feel able to engage with the world. They appeared to experience frustration and anxiety when sensations of body, muscle and joint pain occur because they experience this pain as evidence of personal inadequacy due to inactivity and failure to be productive. These men appear to use physical exercise and working out to relieve feelings of tension and being defeated. Although female participants sometimes talked about the value of physical exercise to manage their emotions or relieve tension, women in this study did not talk about this intertwined complex or syndrome. Although women did seem concerned with how their ways of dealing with experiences of pain reflected on them as people, they did not seem to connect their bodily sensations to their senses of self in such a complex, intertwined fashion. These issues, particularly the syndrome mentioned by male participants, will also be investigated and discussed further in the following chapter, especially in the presentation of the interview with Jack.

Male participants seemed uncomfortable dealing with more emotional and mental forms of pain, while women seemed comfortable talking about more emotional forms of pain. Women sometimes even expressed interest in investigating the relations between physical and emotional pain or talked about how important their emotional responses to pain are to them. In their interviews, men said they tried to avoid discussing emotional forms of pain. Several male participants explicitly commented that they deliberately chose to limit themselves to discussions of physical pain or thought of both physically and emotionally

oriented painful experiences, but deliberately chose to avoid the more emotional experience of pain, deciding to focus on the more physical experiences of pain.

Women talked explicitly about three types of pain, chest pain, back pain and pain associated with their menstrual periods. Of course, men could not talk about menstrual pain. Some women reported experiencing difficulty in obtaining adequate help for their menstrual pain from medical professionals, saying that they were told there was nothing that could be done or that all that was available was the birth control pill. However, women said that they experienced undesirable side effects from taking birth control pills to deal with menstrual pain. Some women said they felt responsible for their menstrual pain and, as a result, did not feel that they deserved help. Other women expressed anger that their concerns about menstrual pain were not adequately dealt with by medical professionals. Women also reported being told that experiencing menstrual pain was just a natural part of being a woman.

Women also talked about two other specific types of pain, chest pain and back pain. Women described chest pain differently from the way in which men talked about pain and tension in their chests related to the syndrome. While women linked their experience of chest pain to tension and stress, they did not connect this experience to their overall senses of self worth, as men appeared to do. Women also talked specifically about back pain, which none of the male participants did. Two of the three women who talked explicitly about back pain mentioned family histories of back pain, both saying their mothers had back pain. All three of the women who talked about back pain described it as an ubiquitous

part of their lives. They talked about this experience of pain saying it makes them feel “non-functional”, that they find back pain “frustrating” and “annoying” and that it makes them feel that they have no control. They reported that back pain interferes with their lives, although they strive to maintain normal routines.

Some female participants talked about pain as completely consuming their consciousness, taking over their entire being. Women also talked about pain in terms of its effects on specific body parts. No male participants talked about pain in either of these ways.

This analysis also revealed differences in the ways women and men deal with pain. Men do not seem to be comfortable with talking to others about their experiences of pain. Male participants said they talk to others about pain as infrequently and as little as possible. Men said that when they do speak with others about pain, they keep their comments to a minimum. Men also reported that they are only likely to talk to others when they are in severe pain or when they feel they must explain why they are not performing adequately. This appears to be related to male participants’ concerns about performing adequately. Conversely, women reported that talking to others about pain was important to them. Talking to others helped them deal with pain and also provided them with information about other people’s experiences and possible treatments.

Male participants also talked about being worried about their experiences of pain while women rarely mentioned worrying about pain. It seems possible that men worry more about pain because they don’t talk with others. As a result,

they do not receive the help in handling pain or the information about other people's experiences and possible treatments which the women do.

Finally, women seemed more inclined to blame themselves for their own experiences of pain. In addition, particularly in regard to experiences of pain related to their periods, women seemed resigned to the idea that they were not likely to receive adequate help from medical professionals for menstrual pain, an experience of pain specific to their gender. Some women also expressed anger about experiencing this type of pain. One women expressed anger about the lack of effective treatment offered her for pain associated with her period and about her difficulties in finding health professionals who would listen to her.

Table 3 :Topics of Participants’ Two Narratives and Two Drawings
Female Participants: Part One

Participant	Archis	Zum	Olivia	Julie	Sooty	Bianca
Narrative #1	Pain from leg, due to groin injury	Chest pain-recent	Issues with father	“Experience which was really the bottom for me”: First relationship with first boyfriend	Bi-cultural experience: not being married according to custom of arranged marriage	Death of her grandmother
Narrative #2	Pain from being touched	Cramps related to period	Shoulder and back pain	Reliving the painful experiences of growing up with alcoholism in order to get over them.	Living in NYC, far from family in London	Injured foot
Map Drawing #1	Little brother threw a stone, hit her under left eye Yard near home	In bed because expecting bad news related to father In bed	Falling and hurting knees in concrete yard of caretaker Caretaker yard	Self and teddy bear in “ hate club”, in closet in her room, wrote out the names of everyone she hated on the wall. Calls this the “ beginning of my isolation”. Bedroom	Mom’s being hit by robber in London neighborhood Neighborhood	Trying to reach through crib bars for baby brother’s pacifier Bedroom
Map Drawing #2	Fall on the beach, on a slippery rock Neighborhood	Ear pain Bedroom	Badly sunburnt lips due to riding in open car with family member Distant	“ Just isolating” in my room with a stolen bottle of whiskey under the bed-depicts self lying on bed. Bedroom	School-room experience; fear of not performing well in new school School	Herself remaining at home in high school while first real boyfriend went away to college Home

Table 3 :Topics of Participants' Two Narratives and Two Drawings
Female Participants: Part Two

Participant	Cathy	Anya	Georgina	Bertha	Jan
Narrative #1	Pain in rib area	Back pain	Frustration	Hurt finger catching football	Back pain
Narrative #2	Pain from menstrual period	Emotional pain	New pain, the pain of writing about pain	Bitten by parrot	Labor pain
Map Drawing #1	Fell and hurt herself in family compound Family compound	Pain due to eczema Bedroom	Neighbor's dog bites her neck Neighborhood	Cut face playing between lawn of house and parking lot next door Space near home	Running into a stage in an auditorium Class trip
Map Drawing #2	Fell in school and hurt knee School	My mom beating me for staying out late Home	Trapped underneath overturned kayak in shallow water Distant	Hurt racing a bus on her bike Neighborhood	Stitches in fingertip Refused to draw

Table 3 :Topics of Participants' Two Narratives and Two Drawings
Male Participants: Part One

Participant	Alasdaire	Kawika	Luke	Jack
Narrative #1	Pain of not working on music	Stomachache	Body pains: muscular and joint pain	Injury to Achilles tendon during basketball game
Narrative #2	Pain of working on music	Injury to knee related to running	Anxiety	Experience of sexual violation
Map Drawing #1	Scene on staircase where he is trying to return to extended family group after “ storming upstairs” because he got really angry. Home	Fall from bike while riding through forest Forest path to Grandma’s house	Scene in mother’s bedroom of shared pain Mother’s bedroom	House where experienced sexual violation House distant from family home
Map Drawing #2	In corridor of public high school in 10 th grade, being led back to Spanish class by House Principal after being suspended from school for cutting Spanish class. School	Scene in school where he experienced fear of failure and alienation School	Scene in physical education class in school which he hated because he felt slow and was made fun of. School	Scene near mother’s house where adult wasn’t supportive and put him in an uncomfortable position Neighborhood

Table 3 :Topics of Participants' Two Narratives and Two Drawings
Male Participants: Part Two

Participant	Sergei	Finn	Paris	Bob
Narrative #1	Falling off a tree	Had to grab some curtains that were on fire	Death of his mother	Severe leg cramps
Narrative #2	Recurrent pain in his finger	One time when he was severely sick at his grandparents house on a very small island in Canada.	Mistreatment by a lover	Running into a basketball pole
Map Drawing #1	Getting hit in the mouth while playing a game with sticks Yard	At about six years of age, playing in parking lot near home Parking lot near home	Tooth chipped while playing kickball Parking lot near home	Running into a basketball pole Sports/athletic field
Map Drawing #2	Beaten up by another boy in a boy's bathroom because of things he said about a girl School	Skateboarding down a really, really steep hill with two friends. Hill near home Neighborhood	Refused to draw second map, but did mention the pain of feeling he was "the only gay man on the planet". Refused to draw	Getting drunk-anyplace, wherever I was Anyplace

Chapter Five

How Does Pain Figure in a Life?: Five Life Sketches

INTRODUCTION TO THE CHAPTER

The major aim of this chapter is to examine in depth the ways five research participants described dealing with experiences of pain over the course of their interviews. This chapter begins with an examination of the stories of three women, Cathy, Bianca and Jan. The interviews with Cathy and Bianca were selected for presentation because they provide insight into the ways in which the two participants who seemed most comfortable in dealing with pain portrayed their experiences of pain over the course of the interview. Both Cathy and Bianca explained that pain was not a major issue in their lives. The stories they tell during their interviews are contrasted to the way Jan portrayed her experiences of pain over the course of her interview. Jan was the participant who appeared to experience the most difficulty dealing with experiences of pain in her life, reporting that she finds pain an extremely troubling experience which both disrupts and controls her life.

The stories of two male participants, Jack and Finn, are presented next. Their stories were selected for presentation for two reasons. First, the stories told by these two men provide good illustrations of the ways in which male participants described looking at and dealing with their experiences of pain. Jack is the male participant who elaborated on the “syndrome” identified by male participants and Finn was one of the three male participants who tried to maintain

a bifurcation between physical and emotional experiences of pain. In addition, since the three participants who seemed to exhibit the greatest and least comfort in dealing with experiences of pain were all women, it was important to present stories told by male participants during their interviews.

Because an important objective of this chapter is to help readers understand how participants portrayed their experiences of pain over the course of the interviews, this chapter describes not only the major themes about which participants spoke, but also the emotions they expressed while discussing these experiences and how their descriptions of their experiences unfolded over the course of their interviews. Each description begins with a quick “reintroduction” of the participant, in the form of a brief review of relevant personal information and demographic data provided by the participant. Next, the “tone” and overall experience of the individual’s interview, including any major shifts in tone and where these occurred, are described. The “shape” which emerged in the interview, the overall structure or organization of the story told by the participant, is also described. Finally, the content of the participant’s comments on experiences of pain in her or his life is examined. Major themes are presented and illustrated with direct quotes and examples recounted by the participant.

PAIN IN THE LIFE STORIES OF THREE WOMEN

I will begin by discussing the interviews with three female participants, Cathy, Bianca and Jan. My attention was initially attracted to the interviews with these three female participants because of the tone and structure of the

interviews. When I examined them more closely, I was startled by the content. I realized that, in the content of their interviews, Cathy and Bianca, despite the important and meaningful differences in family life and culture that they described, both emphasized themes of positive experiences in dealing with pain. Both described themselves as having grown up in homes where pain was handled in a way which they found comfortable and which appeared to provide them with an adequate basis for dealing with the experiences of pain which occurred in their later lives, since they both stated that they were relatively comfortable about dealing with pain as adults. On the other hand, Jan, the third woman whose story is presented in this chapter, portrayed herself as someone who experiences great difficulty in dealing with pain in everyday life. She described herself as an adult for whom pain is a constant and deeply troubling problem and portrayed the way her experiences of pain were handled by her family and friends at different points in her life as problematic for her.

Overall, the interviews conducted with Cathy and Bianca seemed to flow smoothly. The overall tone of both interviews seemed steady and even. Both interviews also had clear, easy to follow structures. Cathy and Bianca's descriptions of their lives seemed to flow out in a continuous pattern which did not leave the interviewer with an experience of "holes" in their stories; the stories which Cathy and Bianca told in their interviews felt "connected".

On closer examination, it was apparent that both these participants provided clear connections between the issues and themes they discussed and, beyond this, were able to explain the meanings these connections held for them.

Because of this, I, as the interviewer, was able to follow their stories easily, although, frequently, the connections they were making were not connections I would have made myself. Bianca even provided concluding remarks that served as a summary of her comments and overall experience of the interview. . At the end of both interviews, although they were long, I, as the interviewer, felt confident that I had thoroughly understood what was discussed.

My impression of the interview with Jan was very different. The tone of this interview did not seem smooth or connected, which made the structure of her interview more difficult to discern. In fact, my first impression was that the structure of this interview seemed rather erratic, which contributed to my overall experience of this interview as one of confusion. Because it was difficult to identify or follow the structure of Jan's story, I often felt that I was not fully grasping what I was being told, although I used all the planned probes and followed the Interview schedule in the same way as in all the other interviews.

When I examined the interview with Jan more closely, I realized that these difficulties in grasping both the structure and content of what Jan was telling me occurred because Jan did not always make it clear on what basis she was forming connections. This often made it difficult to understand how she was relating one experience to another. Moreover, Jan often seemed to form connections between painful events in her life based more on her perception of similarities between the physical experiences, while, for Cathy and Bianca, cultural, social and psychological meanings appeared more likely to serve as the bases for forming connections. Thus, the tone, the structure and the content of

the interview with Jan seemed quite different from those in the interviews with Cathy and Bianca. These differences will become more comprehensible in the following sections, in which each of these three interviews is examined in more detail.

Cathy's Story

Cathy was a thirty-one year old, married woman who was born in Hong Kong but had moved to the United States at the age of twenty-eight (see Table 1). At the time of the interview, she held a bachelor's degree and was working as a research assistant. She was insured through her husband's job and took no medications regularly. However, she said that she sometimes took Advil, obtained over the counter, to deal with pain related to her menstrual periods. She also reported that, to deal with pain associated with her menstrual periods, she sometimes takes "Panadyl", a drug she gets from Hong Kong, although she thinks it is the same as a drug sold under a different name which can be obtained in the United States.

The clear, even tone and structure of the interview with Cathy seemed consistent with the first major theme which she introduced in her interview, that pain has not been a particularly troublesome issue in her life. For example, she listed only three experiences of pain she had undergone in the course of everyday life. This was the fewest number of experiences of pain listed by any of the participants, although two other participants also named only three experiences.

Cathy also demonstrated that she was not overly concerned about experiences of pain in the comments she made about the pain which she chose to write about in her first Narrative. She chose to write her first Narrative about an experience of sharp, sudden pain over her rib area, saying that she chose it because “ It is more interesting. I think not many people experience it”, although she went on to say that her cousin also has this experience and that it first occurred, for both herself and her cousin, soon after each came to live in the United States. However, she did not seem overly concerned about this experience of pain, explaining that she didn’t see a doctor about this sharp pain because, “I was too busy and too lazy. And the pain goes away very quickly. It doesn’t happen all the time. Maybe it’s just stress”, and “Going to the doctor is time consuming. It’s not worth waiting in line unless there are a couple of conditions”. These quotes proved to be typical of Cathy and consistent with her statements that pain usually did not seem to be of sufficient concern to merit a great deal of attention.

Cathy also explained, “My husband sees it [referring to the pain]. He is almost always there and he will see and ask. So, we talked about it”. Talking with other people, especially family members, about her experiences of pain was a second theme to which Cathy would return and which she would also develop further over the course of the interview. For example, still talking about her first Narrative, Cathy said,

I told my mom. Usually, things happen to me and Mom at almost the same time- all kinds of things. For example, one day I was getting off the bus and it stopped early. Her too. I hurt my knee. So did Mom.

Headaches, colds. I have to be careful. If I mention I have something, she gets it in a day or two.

This statement can be viewed as a further development of the theme of talking to other people, especially family members, about experiences of pain. Apparently, this often results in the formation of shared attributions regarding the nature and causes of painful experiences and conditions.

As she continued to talk about the pain in her rib area, Cathy displayed a clear, organized structure, recapitulating her two major themes while presenting an explicit list of three things she does when she experiences pain. First, consistent with the second theme of talking to relatives, she said, "I talk to people, my husband, my cousin, and my mom. I talked to my cousin. It seems like it's a family thing. We talk about conditions and say, 'I have that, do you have that?' My cousin said, 'Yeah'". Second, consistent with the first theme of not being overly concerned about experiences of pain, she repeated, "I thought about going to the doctor, but I didn't go. Going to the doctor is time consuming. I usually don't go [to the doctor] and wait in line unless I have a couple of conditions". However, Cathy emphasized that "I was not afraid to hear the doctor's opinion". Finally, third, again related to talking to family members, Cathy said, "I considered stress, which is my cousin's doctor's opinion".

Cathy chose to write her second Narrative about pain related to her menstrual periods, which she described as, "Very painful for the first day or two". Over the course of the interview, Cathy would have a good deal to say about her experience of menstrual pain, further developing this experience of pain as a third theme in her interview. However, consistent with her overall lack of concern

about painful experiences, Cathy said that she chose the experience of pain related to her menstrual periods, "Because I don't have much to say about number three", referring to the third experience of pain she had mentioned, pain which she experiences in her side and lower thigh.

While talking about her second Narrative, Cathy again presented a clearly structured account of the four things she does to deal with her experience of menstrual pain. Although still not expressing great concern, Cathy did concede that this experience of pain merited both taking medication and a visit to the doctor. First, she said, "I take medication. If I can't take the pain or I need something to do, I take medication". Second, Cathy returned to the theme of talking to others about her experiences of pain, saying, "I talked to the doctor, who said that this is quite normal. It's nothing to worry about". Third, Cathy further developed the theme of talking to others, especially relatives, saying, "I talked to my mom. She said it would get better after I have a baby". Finally, fourth, Cathy said, "I take a Chinese herbal supplement... Oh, I don't consider this a drug. I think of it more as a healthy food."

Although Cathy's comments on her experience of menstrual pain show that this pain does interfere with her life to some extent, her description does not indicate that it causes a major disruption to her life. She may take some medication and even see a doctor, but, for the most part, Cathy describes herself as carrying on with her life. As Cathy explained,

How I feel is the most important, the most important thing is that I can't work well. If I have an exam, I can't do anything. Usually I sleep it away. I stay in bed, read relaxing material in bed. It's really

annoying. I ask, 'Why me? Why wasn't I born a boy or why aren't I a woman that doesn't have pain?

Cathy went on to say, further developing the theme of consulting friends and relatives who are likely to have similar experiences, "Yeah, friends do that [go to bed], and they talk to people and take herbal supplements, something similar to what I do". In addition, Cathy's last comment, 'I ask 'Why me? Why wasn't I born a boy?' may be viewed as a comment on a fourth theme of gender issues regarding pain, which she will develop further over the course of the interview.

Although, at times, Cathy does seem to find the pain associated with her menstrual period more difficult to deal with, the ways in which she described dealing with this type of pain were similar to those she used to deal with the experience of pain in her rib area. She talked to some family members, including her mother and some young aunts on her father's side. She listened to her mother's advice, which is that it will be better after she has a baby. She did choose to talk to a doctor about this experience of pain, and sometimes, but only sometimes, to take medication. The doctor, similar to her mother, explained that menstrual pain is quite natural and nothing to worry about. Overall, once again, Cathy does not seem to be overly concerned about this experience of pain. She portrays herself as dealing with the situation and getting on with her life.

While drawing her first Map, of an experience of pain which occurred when she was six to twelve years old, Cathy said that she could not recall many individual incidents of pain which occurred when she was a child, again, displaying a lack of concern with pain as a troublesome issue in her life. The

occasion she finally chose for her first Drawing served as an excellent example of this. Cathy drew a dog and a person with a ribbon in her hair, saying that this was how she knew that this experience occurred when she was around the age of six, seven or eight, because she was in elementary school at the time and always had a ribbon in her hair. She emphasized that she did not remember just what had happened to her on this particular occasion, explaining that the only reason why she was able to remember this as a specific incident was because of the behavior of the little dog, which licked her face. Cathy said, “It was so sweet that it made the incident special and made it stand out in my mind”. However, Cathy’s next comments, which contain a contradiction, suggested that there might another reason why the presence of the dog made this experience stand out. Cathy particularly emphasized that she didn’t cry, saying, “It was very painful, but I didn’t cry, because I am the oldest. I have to show that ‘I can take it’, not cry but show, ‘I can take it’. But, the doggy came to me and licked the wound. Because the doggy was so nice to me, I cried”. In talking about this experience, Cathy is returning to and further developing the fourth theme, of gender issues in regard to who can display signs of pain in front of whom.

It is important to note the elements of this incident which Cathy did seem able to recall and those which she said she could not remember well. She was able to recall that she hurt herself and that the injury was very painful. She does not deny the painfulness of the injury, saying, “I fell on the floor. I was very hurt. It was very painful.” Moreover, as she drew herself sitting on the ground, holding her leg, she added, “Because it really hurt, [her emphasis] I sat down and

grabbed it". However, on the other hand, she made it very clear that now she could not remember exactly what had happened to cause this, saying, " I fell. I don't remember why." She said that when she walked, or when she ran, she might have just twisted her ankle, or she might have just tripped, she really wasn't able to reconstruct just what had happened. Apparently this aspect of the event had not greatly concerned her.

Cathy was able to give a very full description of who helped her, which relates to her second major theme, talking to relatives about experiences of pain. Cathy hastened to explain that the reason why she was not able to remember individual experiences of pain when she was a child was because she had always been so sure that, whatever happened, many adults would be available to help her, to " fix it". Cathy emphasized that she was always so certain that adults would be available and would help her, especially her mom, her dad and her grandma, that she did not feel very concerned about individual experiences of pain. As a result, she could not remember many of the details of individual experiences.

Cathy linked her certainty about the availability of helpful adults to the structure of the environment in which she often played as a child, raising a fifth important theme, of how the structure of the place affected her experiences of pain when she was a child. She explained that, when she was a child, she and her younger brother played in the compound surrounding her Grandma's house, which had a gate, saying, " My brother and I could go anywhere within the [enclosed] grounds". Within this compound, many of the adults in her family

would always be around, somewhere fairly nearby. The adults might have been working in the small garden where they grew vegetables or doing something in the area where the chickens were kept. But, Cathy emphasized that she knew that many adult members of the household were always nearby and that many of them would come running to help if anything happened,

She said that she thought that, on the occasion she depicted, she probably was not so badly hurt that she wouldn't have been able to walk to the house to get help from adults, and that she probably did. However, she emphasized, once again, that there were so many adults around all the time that, even if she had not been able to go to get help, some adults might have come out to see how the children were doing and realized that there was a problem. It is notable that she is so comfortable with the idea that adults would be there, when needed, and would do what was necessary to help her, that she doesn't remember exactly how the adults were alerted to the problem. She said that she knew that, if she actually shouted, adults would come right away. Her Dad, in particular, would come running. Because of this, "I was never afraid at all, although it was a big place". She went on to say that, based on many such experiences, she knew that an adult or some adults would see her and care for her. She said that she remembered that she didn't really care what they did, because, "I knew that it would be fine."

Cathy further explained how adults dealt with experiences of pain, saying, "They would probably have said, 'What happened?' and then have gone on to say something about my having been so clumsy". She said that, in her family,

adults usually said something about being clumsy to a child who injured herself. Cathy stated that such conversations were conducted as a way of warning the child to be more careful and more aware, in order to prevent future injuries. As Cathy explained, “The adults’ tone would have been really concerned. They would have said things such as, ‘How come you’re so clumsy?’”. But, all of this was done in order to express concern and tell you to be more careful. This is what happened in my (her emphasis) family.”

While discussing her first Map, Cathy also returned to her fourth theme of gender issues in regard to pain, elaborating on her view of the relations between issues of gender, status and power while talking about who can display signs of pain, such as crying, in front of whom. Cathy expressed her concern that, in dealing with pain, she would be “able to take it”, explaining that she didn’t cry because her younger brother was there. Since she is the oldest child, it was important to “Show that I can take it, that I not cry but show I can take it”. Moreover, she was concerned that “He shouldn’t see me cry”, even if the treatment proved to be painful. Cathy went on to connect her view of relations of gender and power to her own identity, saying, “I was concerned about what crying would mean to me, my identity, myself as the stronger one in the family. So, I can’t cry.” However, she went on to say, “A ‘doggy’ came to me- and licked the wound. Because the doggy was so nice to me, I cried”, once again introducing a contradiction and suggesting that her remembrance of this particular experience might be more closely tied to themes of gender, status and power than Cathy has overtly acknowledged.

When asked whether this experience mattered to her, whether it was significant in her life, Cathy said that, in general, she wouldn't cry when she had pain, explaining that, in the culture in which she was raised, you could cry very easily in front of certain people, but not others. As an example, she mentioned her husband, saying that now, as an adult, she can cry in front of her husband, because,

It is OK in my culture to cry in front of your husband because a woman is supposed to be weaker than a man. However, when I was a child, it wasn't like this with my younger brother. I was older, so I was supposed to be stronger, so it was not alright for him to see me cry.

However, Cathy went on to explain, "At some point, while we were growing up, his being a boy overtook his being younger. It mattered more that he was a boy."

The current situation between herself and her brother, now that they are both adults, appears to be something of a mixture. Cathy said,

Now that we are both adults, my younger brother wouldn't cry in front of me because he is a male and considers himself the stronger. However, I still won't cry in front of him, even if he does consider himself stronger.

Even if her brother now thinks that he is the stronger, Cathy still will not cry in front of him and risk losing the status she holds as the older sibling. Further, regarding this issue of shame and status in regard to who can reveal weakness to whom in Cathy's culture, it is important to mention that, in both her drawings, Cathy depicted herself with her back to the viewer. She was the only participant to illustrate herself with her back to the audience.

Still talking about gender issues in regard to pain, Cathy described her relationship with her father, saying that she is very close to him and that she is his favorite because she is the first born. She depicted the way her father deals with pain, saying,

He wants you to look up to him. You can see it [pain] in his face, but he won't talk about pain. He would see a doctor, if Mom pushes him, but not right away. He would rather go to work. It has to be something serious, not just pain, to pay money and spend time.

Cathy's description of her father's behavior when he experiences pain is similar, in many respects, to Cathy's descriptions of her own behavior regarding pain, especially not consulting a doctor unless a condition appears to be serious.

In addition, Cathy talked about gender differences in caregiving, saying that, although she couldn't remember exactly who had been there, the people present in this incident would definitely have included her father, mother, her grandma and younger brother. She added that it was also highly likely that a number of aunts and uncles would be there to help. However, she explained that, of all these people, the one who always was sure to be present to help her if she was injured was her mother. While it was possible that, sometimes, her father would not be there because he was out working, "My mother, especially would be there. Yes, definitely."

However, when Cathy was asked to draw her second Map, of an experience of pain which had occurred in her adolescence, when she was ages twelve through seventeen, the smooth tone of the interview with Cathy shifted slightly. This was another example of an interview in which the drawing of the

second Map appeared to cause difficulties. Cathy put her head in her hands. She seemed to be experiencing some distress and said that she needed to go to the bathroom. Throughout these interviews, I noticed that participants sometimes used a trip, or even several trips, to the bathroom to create breaks in the interview, particularly at points where they experienced discomfort. This was most noticeable in the interview with Julie, who made several trips to the bathroom, explicitly stating that she really needed to take a break. Julie was also the participant who was most overtly emotional during the interview, crying frequently. After Cathy stated that she wanted to go to the bathroom, she apologized, saying, “I don’t know why I need to go to the bathroom so much today. But, I’ll think while I am on my way there”. When she returned, she said that she was still having difficulty identifying an experience of pain which occurred while she was within the specified age range. As Cathy said, “I can’t think of anything at that age. Eleven, but not after”, although she went on to say, “I probably did hurt myself between the ages of twelve and seventeen”.

Cathy finally picked an experience which occurred when she was still eleven, but very nearly twelve, saying that this was the best she could manage. Showing me the scar on her knee which resulted from this experience, Cathy said,

I was in school. There was a break in classes. I fell again and hurt my knee. But, I didn’t go to the nurse. It was too embarrassing to go to the nurse. People would talk about it. Although, the guy I liked at the time told me to go to the nurse.

Cathy drew several people, saying that the people present included her mom, her dad, four or five of her friends, the guy she liked and some of his friends and one or two teachers. Once again, Cathy raised three key themes: that pain has not been a particularly troublesome issue for her in life, that she has many people available to help her and talk with her when she is injured, including both family members and friends, and that it is important to her to show that she can “take it”. Cathy explained that, when she did go home, at the end of the school day, both her mom and dad helped her. They cleaned the wound, talking with her and soothing her as they did so, developing the theme of family members being both available to help and willing to talk with Cathy about her experiences of pain. Somewhat surprisingly, in regard to gender differences in caregiving, Cathy also said that her father was more likely to soothe her, while her mother was more likely to ask her why she had been so clumsy.

Consistent with both the themes of not being overly concerned with pain and being able to “take it” without showing signs of pain in front of other people, Cathy repeated that she did not go to the nurse, at first. When she finally did go to the nurse, Cathy added, “ But I didn’t go home early. I went back to class”, consistent with her need to show that she can “ take it”., concluding her story with the statement, “After, how I could take it was important in my life”. This statement points to the significance of this experience in her life. It appears to form a nodal point, at the age of eleven, when she began to experience conflict related to gender in her stance toward pain. In the scene Cathy depicts, her determination to show she can “ take it” comes into conflict with the expectations

of others, including adults and “the guy I liked at the time”. Such a view of the significance of this story may also explain why portraying this story seemed to refresh Cathy’s memories of her life when she was ages of twelve through seventeen. After talking about this experience, Cathy spontaneously offered another example which actually took place during the age range asked about, when she was between the ages of twelve and seventeen. She explained that she couldn’t get the lid off a can she was trying to open, and, as she put it, “ I took a chunk out of my finger. But, I showed I could take it”.

Finally, in the closing section of the interview, Cathy was able to quickly and easily summarize the ways she deals with pain, drawing on the four themes which she had been developing throughout the interview. Once again, she created a list of three items. First, she drew on the fourth theme, of gender, saying, “ I show I can ‘take it’ and I won’t cry in front of anyone, except my husband. Except my period. For that, I take medication”. Repeating the second theme of having relatives and friends who help her and with whom she can talk about experiences of pain, she said, “ I always see that people will take care of me. A doctor maybe, if it’s something really painful. But, if I have any pain, someone will be there for me. And, I talk to people. I get information and they tell me how to handle it”. At this point, Cathy elaborated further on the large number of relatives and friends in her life on whom she can count for help, explaining,

They will discuss it with me. They usually tell me to see a physician-but I don’t. But, I don’t tell them that. We try to see if we’ve had a similar experience. Also, they take care of me. Do anything they can to help.

Tea, medication-they'll get anything I want if they can do it.

Asked how they treat her, Cathy replied without hesitation, " Really well". As her fourth point, Cathy repeated the first theme she had introduced, that of not being overly concerned about experiences of pain, emphasizing once again that she usually doesn't go to the doctor unless the condition is very severe. However, when she does consult a health care professional, Cathy commented, " They treat me really well and are willing to spend time with me. My physician is real nice. She talks with me", returning again to the theme of having people in her life on whom she can count and who will talk with her about her experiences of pain, including health professionals.

Regarding how pain affects her view of herself, Cathy said that it is really her view of herself which affects the way she deals with pain. As she explained, "It's the other way around. In life, I see the difficulties. But, I won't lose. I can manage. The way I deal with life, I use it to deal with pain". Asked if this way of looking at her experience of pain helps her in any way, Cathy replied, " Maybe. Because if I get reinforcement when I encounter pain and handle it, the next time I know I can manage. It's a cumulative effect. When I hurt my ankle, I saw I couldn't do anything, but I thought, 'I won't lose'." Cathy also provided another example, saying, "I had to have a blood test. I was very afraid. I thought it would be very painful. But, the next time it was better. Then, even better. I thought about injections, and I thought, ' I can handle it'." She said that this way of looking at pain does help her get on with her life. She doesn't know why her experiences of pain occurred, although she does not think anyone was at fault.

However, she said that not knowing why experiences of pain occurred does not bother her. Cathy explained further, “It just happened. It gives me confidence I can deal with it.” At this point, Cathy stated, “I don’t associate these incidents together”. This comment will be investigated further in the context of Jan’s life stories and discussed in the final, summary section of this chapter.

Concluding, Cathy said,

I thought the interview was pretty good, although it was kind of long. I enjoyed the process. These things, they were really important. I still mention them to people. It’s [the interview is] official. You asked and I told you. It was focused. I saw more about it- this incident. Why it was important. I gained insight.

It is interesting that Cathy’s concluding comments seem somewhat similar to those made by Bianca, who specifically stated that she had gained insights into her experiences of pain through participating in the interview, then drew on these insights to begin to make conjectures about pain.

To summarize, Cathy’s interview had a clear, consistent tone, with the exception of the beginning of the second Map drawing, at which point she exhibited some signs of mild distress and asked to take a break and use the ladies’ room. It is interesting that the experience of pain she he finally chose to talk about occurred slightly prior to the age range specifically asked about for the second Map and caused her to make an observation which seemed to somewhat surprise her, that this incident was important in her life because afterward it became important to her to show she could “ take it”.

The five major themes which Cathy introduced during her interview and to which she kept returning, intertwining and developing them throughout the course of the interview, were: 1) pain is not an overly troublesome issue in life for her, so that it is not necessary for her to deny experiences of pain, 2) other people, especially friends and relatives, are always present and available to both help her and to talk with her about experiences of pain, 3) gender issues are very important to Cathy in the way she deals with pain and she connects these gender issues to issues of power and status, making Cathy very concerned to show she “can take it”, 4) Cathy’s experiences of menstrual pain are more severe than other experiences of pain. However, in large part, she deals with these experiences in ways similar to the ways in which she deals with other experiences of pain, 5) the structure of the environment, especially during her childhood, played an important role in the way her experiences of pain were handled.

Cathy depicts herself as someone who is not overly concerned with experiences of pain in her life. The overall tone of her interview, which was smooth and consistent, and the clear organization of her interview tend to confirm her verbal comments. She highlights the willingness and availability of family members and friends both in helping her substantively and in talking to her when she experiences pain. This seems to have contributed to her general comfort regarding experiences of pain. Especially in her childhood, such helpful behaviors on the part of significant adults seem to have been facilitated by the structure of the environment, a family compound in which adult family members

were also close by and available. However, Cathy also introduces the theme of who can show signs of pain in front of whom. She relates showing signs of pain to displaying weakness, and connects this to themes of gender, power and status, explaining that, in her culture, only those of lesser status can display signs of weakness to those of greater power. She was the only participant to depict herself in her drawings with her back to the viewer, which she did in both her Maps. She explains that her father, to whom she was very close and a favorite because she was the first born, does not display signs of pain to others. Moreover, in her culture women are viewed as weaker and of less status than men. These concerns seem to play a dominant role in her strategy of showing “I can take it” when she experiences pain.

Bianca’s Story

Bianca was a thirty year old married woman born and raised in Queens, New York (see Table 1). When the interview was conducted, she had just completed her master’s degree and was employed part time as a research assistant. Like Cathy, she is insured due to her husband’s job. She does take some medications, including asafex for an acid reflux condition and a prescription antibiotic for her skin.

While reviewing my notes on the interview with Bianca, I was struck again by the ease with which this interview had proceeded. The tone of the interview with Bianca was even and consistent. Just looking at my notes on this interview provided information on how smoothly this interview had gone. Most of the

interview forms were covered with quickly jotted notes, which frequently went beyond the boundaries of the spaces provided, overlapping onto the backs of nearby pages. However, because Bianca easily adapted her responses to the structure of the interview, the form used in my interview with Bianca was neat and easy to read. Bianca appeared to experience no need to take control of the interview, at any point, yet she also appeared entirely comfortable and in command throughout the interview. On closer examination of this interview, I also became more aware of the clearly organized structure of the interview with Bianca. Similar to the interview with Cathy, she tells a story that feels “connected”. Her description of her life seems to flow out in a continuous pattern which does not leave the interviewer with an experience of “holes” in her narrative. Like Cathy, Bianca introduced several key themes, to which she returned, developing them further over the course of the interview. Not only was Bianca able to tell her own, unique personal story, providing rich, complete data, but, I realized, she was also able to use the interview as an opportunity to take chances and explore her experiences, without appearing to experience any discomfort in doing so.

In terms of content, Bianca’s story is also similar to Cathy’s in many ways, despite the differences in culture and in where they were born and grew up. Bianca described a situation where, as a small child, people in her family were not only readily available to help her when painful experiences occurred, but were also willing to talk with her about her experiences of pain. Perhaps because of this, as she grew older, she, like Cathy, talked to friends, as well as

family members, about her experiences of pain. Also similar to Cathy, Bianca expressed an ability to deal comfortably with pain, portraying herself as an adult for whom pain is not a terribly troubling issue.

Very early in the interview, Bianca's willingness to use the interview as an opportunity to explore, displaying curiosity and active interest in the topic, emerged as a theme. Bianca explained that she chose the topic for her first Narrative, the death of her grandmother, "Because it was more personal to me than deaths in my husband's family, although they were difficult for him.", exhibiting a willingness to consider deeply personal, painful events. About her choice of her foot injury as the topic for her second Narrative, Bianca said, "I chose it because I thought it would be a contrast, the physical versus the emotional. I was curious about what might be different, how different pain, emotional and physical, affected me", again displaying eagerness to investigate previously unexamined aspects of her experiences of pain, in this case the relation between physical and emotional pain, a topic in which several female participants expressed interest. Bianca also displayed a willingness to explore when she selected the subject for her first Map. Saying, "I'll probably go with the first thing that comes into my mind", she selected a scene which took place in the bedroom she was forced to share with her brother, who had just been born.

Asked what she did about the experience of pain she wrote about in her first Narrative, the death of her grandmother, Bianca introduced a second important theme, which she shared with Cathy, being able to talk with family members about painful experiences, saying, "I talked about it, to my husband,

mother, father and brother". Asked if anyone in her life tended to talk with others when they experienced pain, Bianca replied immediately, " Yeah, everybody in my family except my father! My mother, brother, aunt, uncles, cousins, husband". It was at this point in the interview with Bianca that I began to realize how easily and smoothly this interview was proceeding. Bianca was very responsive to the probes I was using, waiting to hear the questions, then responding clearly and appropriately to just what was being asked, in a very targeted manner.

I also became aware that Bianca seemed to be comfortable in expressing her feelings about this painful experience. Bianca's comfort in expressing her strong feelings about experiences of pain in her life was a third theme in her interview. For example, asked how she felt about the death of her grandmother, Bianca replied very candidly, saying,

I felt badly for not feeling bad. I felt bad about how my father felt. It's hard to watch a parent's distress. Also, she wasn't the easiest person to get along with. And I wasn't sure what to say. It's harder when it's your parent or someone close to you. Also, I felt guilty for not being close to her.

In her portrayal of this experience, Bianca is talking about both her own pain and the pain she felt for her father.

For her second Narrative, Bianca chose to write about a foot injury which had occurred about nine or ten months previously. Again, like Cathy, she did not appear to think that experiences of pain merited a great deal of attention or to be overly concerned or vigilant in regard to experiences of pain, a third theme in her interview. For example, similar to Cathy, Bianca did not appear to remember the

details of this painful experience. She said that she was not entirely sure where the injury had occurred. As she put it, “No special place. It probably began at the gym. I don’t really remember for sure”. Again, similar to Cathy, Bianca admitted that she hadn’t done anything for a fairly long time after the injury. As she explained, “ Finally, the pain was so constant, I went to the doctor, after about seven months, in early October”. Asked how she felt about this experience, Bianca, again, was comfortable expressing strong emotions, saying,

I felt angry, frustrated, worried. I am too young. I go to a physical therapist, I am always the youngest person. It’s annoying. One thing makes me wish I was not bothered by this. It prevents my exercising. Exercise is very helpful to me for stress reduction. Also, it helps me keep my weight down.

A fourth theme in the interview with Bianca was surprising. As Bianca talked about experiences of pain in her life, she made it clear that she thought that pain had affected many areas of her life, but in positive ways. Bianca offered descriptions of ways in which experiences of pain have had positive effects on her life, especially in helping to foster connections to people who are important to her in her life. For example, Bianca said, “ My family and friends are likely to be around. They are a huge source of support and pleasure for me, the people who are consistently there when I feel pain.” When asked about what areas of her life she thought pain had affected, Bianca said,

I guess because a lot involves people. If I experience pain, I call in family and friends to help, so it affects relationships. And, mostly, it strengthens these relationships. I know I can count on people. My relations with friends and relatives are enhanced by supportive, helpful relationships.

Not to paint too rosy a picture, Bianca went on to acknowledge that relationships have their good and bad features, saying, “Relationships can really hurt”. However, Bianca described a network of people, family and friends,” who listen and are supportive.”

Thinking about the effect her experiences of pain have had on her view of herself and on her life, Bianca further developed this fourth theme of the positive effects on her life of experiences of pain. She explained that the ways people deal with her when she experiences pain help her as person, saying, “ Yeah, it helps me to know that there are people I can count on”. Bianca combined the themes of having people in her life with whom she can talk about experiences of pain and finding that pain has affected her life in many positive ways when she described herself as someone who is not only able to deal with experiences of pain, but to use them as a source of growth. As Bianca put it, “I talk about it, try to learn something from it”. As to helping her get on with her life, Bianca said, “Yeah, if you come to terms with something, you can move on. Sometimes it takes longer than other times”. Like Cathy, Bianca describes herself as someone who can draw upon painful experiences for growth.

Consistent with the first theme, being interested in using the interview as an opportunity to investigate her experiences of pain, Bianca further explored possible differences in her experiences of physical and mental pain, while also developing her second theme, that she has supportive, helpful people in her life who are willing to talk with her about painful experiences. Bianca explained that there is a distinction between the kinds of support her family and friends are likely

to offer when she experiences physical pain versus emotional pain. She emphasized that family and friends are more likely to suggest taking that action in regard to physical pain, such as going to a doctor or undertaking some activity. However, Bianca said that when she experienced more emotionally oriented pain, her family and friends were more likely to just listen. As she put it, in regard to emotional pain,” People close to me will probably be not so pro-active, more ‘I understand how you are feeling. I went through the same thing’.”

Bianca returned to and elaborated further on her second theme, having people in her life who will help and talk with her, saying, “ I think I can count on people to ‘listen’ and ‘be there’ [when she experiences pain]. I feel sure that people will treat me nicely and be supportive and helpful”. She expressed certainty that people close to her will spend time with her when she has painful experiences, saying, “ Oh, yeah. It has really never been an issue. I have never had someone say, ‘I can’t listen anymore. I have to go’”. She went on to say there are about fourteen people on whom she feels she can count to help her when she experiences pain, about half friends and half family, commenting, “I always feel I can talk to people. I am very lucky. I have somebody always who listens.”

For her first Map, Bianca chose to portray a scene in her bedroom in which she was trying to reach through the bars of her baby brother’s crib to get his pacifier for him. Bianca explained that she was interested in this experience because, as she put it, “It doesn’t seem significant, but it is. It’s so clear and vivid in my mind. It had to have mattered. I have a very clear memory of that and I

was so young. It's unusual". Other participants made similar comments about the vivid quality of some of the scenes they chose to depict. For example, when Luke described the first Map he drew, of a scene which occurred when he was six years old, he also emphasized how vivid his memory of this scene remains for him. He explained that he thinks this memory stayed so clear and vivid because, although this scene was very important to him, it remained detached from any meaning for a long time. It was not until he was much older that he was able to understand what had taken place on the occasion he depicted. Before he understood its meaning, the scene remained in his mind as a static, vivid memory.

It seems that Bianca has still not discovered why she has such a vivid memory of this scene nor why the scene seems so important to her. However, as she talked, she revealed that this bedroom had been hers before the birth of her brother. After her brother was born, she was forced to make many adjustments, including sharing the bedroom which she valued highly. She commented several times while discussing this Map that "boys are so different" and "things changed so much". Similar to the experience Cathy depicted in her second Map, it seems likely that this scene involves themes related to gender. The story portrayed by Bianca revolves around the arrival of a baby brother who represented a valued male member of the new generation and whose birth changed many aspects of Bianca's life. Like Cathy, Bianca does not seem to be completely aware of the significance of this experience or of its relation to gender.

Bianca also talked about her experiences with health care professionals, saying, “ For physical pain alone, I go to the doctor. Going to the doctor is not a big deal”. Here, again, she is similar to Cathy, who reported that she does go to the doctor when she thinks it is necessary. However, unlike Cathy, who said that she has a very good relationship with her doctor and feels she can talk to her, Bianca said that her interactions with medical doctors are not always satisfactory, especially because they often don’t devote enough time to listening to her and allowing her to express her feelings and fears. Bianca is consistent in her descriptions of the sorts of behaviors which she does and does not find helpful. She described medical personnel as not doing exactly those things which she described herself finding helpful in her interactions with family and friends, listening, expressing understanding, and telling her about similar experiences of their own. Bianca explained that the sort of helpful, involved communication she is used to with her friends and family helps her to know what to expect.

When Bianca was asked how she tolerates pain, she said, “ I wouldn’t say that I am great at it”. This seems similar to Cathy, who also said she did not think she tolerated pain particularly well, no better than most people. Cathy was able to acknowledge that her injury hurt quite badly, but reported being sure the adults would be able to “ fix it” and that they would talk with her about it, including talking with her about the pain that might be involved in treating her injury. It seems possible that, like Cathy, because she feels that other people will be available and willing to both help her when she experiences pain and talk with

her about her experiences of pain, Bianca is not overly concerned with being stoic or with denying pain. She seems quite comfortable with the idea that she tolerates pain about as well as most people, no better. Bianca said that, when pain occurs, she acknowledges it, deals with it, which includes talking to people close to her on whom she feels she can rely, and tries to move on, to get on with her life, again, similar to Cathy.

Bianca's characterization of how she deals with pain includes her feelings on the issue of responsibility. Like many participants in this study, particularly women, Bianca feels that she herself is responsible for pain in her life, such as the foot injury she described and wrote about in her first Narrative. Bianca explained that she feels responsible for dealing with her foot injury, despite the fact that the cause of this foot injury has not been determined. When asked if this view of who is responsible affected the way in which she dealt with pain, Bianca said, "Yeah, it makes me angry with myself for not taking care of it sooner."

The way in which Bianca chose to deal with the end of the interview was very similar to the style of dealing with pain in life which she had just described in the interview. In the closing section of the interview, when Bianca was asked about her experience of the interview and whether she had anything to add, Bianca chose to reflect on her experience, which offers support for her claim that she tries to deal with pain, learn from it and move on. She said, "Writing about things gave me a chance to put feelings into words. I learned something. I realized that my foot is more of an issue than I thought". She went on to make

some comments that I think will prove helpful in understanding why this way of dealing with pain in her life seems to be so positive for her, saying,

Talking about how people deal with pain is helpful. I see what I can do differently...I learned that I am very lucky. I have a good support system. People understand. It makes me feel that I am not alone, not nuts, not crazy to feel like this. Others have been through this and they came out and survived.

To summarize, the interview with Bianca had an even, smooth tone and clear, easy to follow structure. Bianca seemed quite comfortable throughout the interview, easily fitting her answers into the structure of the interview without sacrificing any of the richness or individuality of her own construction of her experiences of pain. Similar to Cathy, Bianca developed, returned to, and intertwined five major themes: 1) she both expressed and displayed curiosity and an active interest in the interview, and a willingness to use the interview to explore, 2) other people, especially friends and relatives, are always present and available to both help her and to talk with her about experiences of pain, 3) she both expressed verbally and demonstrated that she is comfortable expressing strong feelings about her experiences of pain, 4) pain is not an overly troublesome issue in her life; she is not overly concerned about experiences of pain and does not find it necessary to deny experiences of pain, 5) surprisingly, Bianca thinks that experiences of pain have had a positive effect on many areas of her life, especially serving to foster enhanced relationships with others and helping her view herself positively because others are willing to help and talk with

her. Bianca explained that experiences of pain have been a source of growth for her.

Finally, like Cathy, Bianca introduced and developed an important story related to gender, place and pain. Similar to the scene Cathy portrayed in her second Map, Bianca, in her first Map, depicted an experience which she said occupied an important position in her life. However, again like Cathy, she was not able to articulate the reasons why she felt this experience was so important. The experiences related by both women suggest that these “gaps” in the stories they told are related to themes of gender and realizations that, as females, they are finding themselves positioned in the world in ways with which they are not entirely comfortable.

Jan’s Story

Jan was the forty-eight year old married woman who was born in a small city in Pennsylvania and raised in a borough of New York City, where she has lived for most of her life (see Table 1). At the time of the interview, she had attained the highest level of education in this group of participants, a doctoral degree, and was working as a professional researcher. Jan uses a number of medications, both prescription and over the counter, and the services of several types of health care professionals, including a chiropractor.

While the interviews with Bianca and Cathy seemed to flow and I was easily able to follow the connections they were making, I often had difficulty following the story Jan was telling, although I followed the same interview

structure and used the same probes. Unlike the interviews with Cathy and Bianca, both the tone and the structure of the interview with Jan seemed unclear and uneven. During much of this interview, the structure of the interview was not apparent to me. I frequently felt that I had, somehow, not fully understood what I had been told. Jan herself stated, at the very beginning of the interview, that she needed to feel that she was in control. On reflection, this appeared to affect both the tone and the structure of this interview. When I was able to examine this interview in more detail, I realized that much of the structure of this interview was based on Jan's forming connections between experiences of pain which she found similar. In addition, unlike Bianca, often Jan did not respond to the specific issues she was being asked about in the interview.

At the very beginning of the interview, Jan brought up what was to be a central theme in her interview, that she is extremely sensitive to pain. Unlike Cathy and Bianca, who explained that they were relatively comfortable with experiences of pain, Jan emphasized that pain is a major issue in her life during the first part of the Narratives Protocol, in which she was asked to tell the researcher about some of her experiences of pain, saying, "I am very sensitive to pain. Do you just want me to keep going?", implying that her list of experiences of pain was likely to be much longer than most people's. In fact, Jan listed about the same number of experiences of pain as the other participants. Jan was also one of the few participants who reported doing any on-line reading about pain, saying she had done a great deal of reading on-line about experiences of pain. Talking about her on-line reading about back pain,

Jan explained that she was particularly struck by a piece which informed her that “pain should not be a reason to commit suicide” a startlingly vivid statement which provides insight into just how troubling Jan finds her experiences of pain.

Jan also brought up the second major theme, her need to feel that she is in control, very early in her interview. When the researcher asked her to select a second experience of pain from her list and spend about ten minutes writing about it, for her second Narrative, Jan both expressed verbally and displayed her concern over issues of control saying, with some chagrin, “How many will I have to write?” When the researcher told her that several participants had asked about this, because they were concerned that they would be asked to write about all the experiences of pain they had mentioned, not just two, Jan replied to this information by saying, “It’s me. I need to know what to anticipate. It’s a feeling of control. I need to feel in control.”

Also consonant with a need for control, Jan was the only participant who expressed displeasure about the period of time allocated for writing each Narrative, ten minutes. When she was told that the ten- minute period for writing her second Narrative was almost up, Jan said that she had more to say and really needed more than ten minutes. This also provides an example of her tendency to want to structure her interview in her own way, rather than following the overall structure of the interview in expressing her own constructions and ideas, as Bianca and Cathy did.

In addition, Jan, who was interviewed in the summer of 2003, was one of only two participants who made any mention at all of the subject of 9/11, and the

only participant to bring up the subject of Y2K.. “Y2K” refers to the concern at the change of the millennium on January 1, 2000, that the change in date would confuse computers sufficiently to disrupt normal life. “9/11” refers to the terrorist attack which occurred on September 11, 2001, destroying the twin towers of the World Trade Center in downtown New York City and killing thousands of people. 9/11 was a devastating event which left many New Yorkers seriously troubled. Instances of post traumatic stress syndrome occurred frequently and it has been reported that many New Yorkers are still experiencing distress in the aftermath of 9/11. However, in this group of participants, only Jan referred to this event at any length. Moreover, Jan not only referred to both these event, but she also offered lengthy explanations of the lasting effects these two events have had on her, reporting that she still maintains the stock of water and canned goods she bought in anticipation of Y2K and the supply of cash, duct tape and plastic sheeting she acquired after 9/11. Since all the interviews in this study were conducted in New York City during the summer and fall of 2003 and the winter of 2003-2004, with people who were residents of New York City, most of the participants in the study had experienced both of these events. However, Jan was the only participant to talk at length about these two recent and troubling experiences and also the only participant to describe ongoing effects of these two troubling events on her ongoing, daily behaviors.

A third major theme in Jan’s interview was that of experiencing back pain. Jan chose to write about her recent experience of back pain for her first Narrative. She then proceeded to link this recent experience of back pain to an

experience of back pain which had occurred five years previously. For her second Narrative, Jan chose to write about her painful experience of back labor when her first child was born, over twenty years previously. Jan formed connections between these three experiences of back pain throughout her interview. This pattern of forming connections was different from Cathy's and Bianca's. Jan seemed to connect the experiences she discussed on the basis of her subjective experience of the pain itself. Both Cathy and Bianca discussed the experiences of pain they brought up in their interviews in terms of the ways in which these experiences had figured in the overall patterns of their lives. They seemed to strive to explain the meanings these experiences held for them. When they had difficulty finding meanings, as when Cathy didn't seem to realize the possible significance of her need to show "I can take it" when she fell in school and when Bianca seemed uncertain how to explain the significance of her experience trying to get her brother's toy through the bars of his crib, these stood out as "gaps" or "holes" in their stories. However, Jan did not seem to be able to explain the bases on which she was forming connections between the three experiences of back pain she talked about. This way of forming connections between experiences of pain was an important factor in this interview, helping to explain my difficulty in grasping the structure of this interview and why I sometimes experienced difficulty in understanding and following the connections Jan was making. Jan's discussion of her experiences of back pain in her first and second Narratives provides an excellent illustration of the way Jan

constructed and connected the painful experiences she discussed in her interview.

About her recent experience of back pain, the subject of her first Narrative, Jan said, “It was very upsetting. It happened before, which left me vigilant”. Although I only realized this after careful study of this interview, this is also a theme in Jan’s interview, one to which she returns often, vigilance and that the memory of a similar painful experience exacerbates the troubling qualities of a more recent experience of pain which seems similar to her. She went on to talk about her previous experience of back pain, saying, “ I had a pretty severe reaction to having it five years ago, when it lasted for a few weeks”. As a result, she described herself as being “ stunned” when it happened again. She said she had been at home when it happened the first time, five years before. She was at work the second time it happened.

This fluid movement between experiences of pain happened frequently in Jan’s interview. In comparing the two experiences of back pain, Jan goes back and forth repeatedly from the current experience of back pain to the previous experience five years before. It was not always clear, in the midst of the interview itself, to which experience of pain she was referring. At times, Jan herself talks about the two experiences as though they were one experience, separated only by a period of time. Moreover, Jan herself did not explicitly comment on the way in which she was connecting these two experiences. It appears to be the experience of pain itself which forms the basis on which Jan connects these two experiences of pain.

For her second Narrative, Jan chose to write about being in labor with her first child, another experience involving a form of back pain called “back labor”, which she said is extremely painful and very unusual . She said she chose this topic because, “As soon as I heard the question, it struck me as one of the most painful experiences of my life”. She went on to explain that the doctors at the hospital where she had the baby gave her demerol, which she didn’t like because it “took away my sense of control”, returning again to the second theme, her need for control. She went on to say, “ My back pain now is like non-stop labor”, again, forming a connection between similar experiences of pain. She also said, “ I was really traumatized, even though the pain was short. The flashback from last time affects you”, again, forming a connection based on the experience of pain itself and emphasizing that the previous experience made the later experience more troubling.

While reviewing this portion of the interview, I again realized that one of the reasons I sometimes found it difficult to follow Jan’s story during the actual interview was because it was not always clear to which experience of pain she was referring. As in her discussion of her first Narrative, Jan moves rapidly and fluidly between the experiences of pain she discusses. Later in the interview, while talking about the experience she depicted in her first Map, Jan herself says that she is not sure which of two painful experiences she is thinking of when she says, “I am not sure whether I remember this doctor’s office or have it mixed up with the office of my son’s orthopedist.”

Later in the interview, Jan explained that, the second time she had a baby, “I had a mantra for myself, telling myself that it would be “quick and short””. However, Jan did not offer additional information on this second birth until much later in the interview, towards the end of her discussion of this second Narrative, when she offered the information that, in fact, this second birth was “quick and short.” In the interview with Jan, topics tended to be introduced, then dropped, then picked up again much later in the interview, without explicit mention of their having been discussed earlier. Usually, when these topics were reintroduced, no explanation was presented of their relevance to the issue being discussed at that point in the interview. Again, it appeared that the connections Jan was making were often based on her subjective experience, which was not always fully explained to the interviewer. These characteristics of the structure of Jan’s interview often made it hard for the researcher to follow what she was saying as the development of a topic. Nevertheless, like Cathy and Bianca, Jan has introduced central themes, which are: 1) that Jan is unusually sensitive to pain, 2) that she needs to feel in control, 3) that back pain is a particularly troubling type of painful experience for her, and 4) that the memory of previous painful experiences which seem similar to current ones contributes to the troubling nature of current experiences of pain and adds to her vigilance and senses of foreboding and loss of control.

Still talking about her second Narrative, about her experience of back labor over twenty years previously, Jan went on to say more about the first time she experienced back pain, five years previously, saying, “ I laid in bed for five or

six days, because I didn't know of any alternatives". She said, " The doctor said to wait, but, later, when the back pain persisted, he suggested going to a chiropractor". In addition, Jan said that the doctor finally gave her a prescription for an anti-inflammatory medication. When the back pain recurred, referring to her most recent experience of back pain, although she did not specifically identify it, Jan said that she went directly to the chiropractor and immediately called the doctor, asking for anti-inflammatory medication. She also obtained some over the counter medication for pain and used ice packs. Jan is somewhat unusual in this group of participants in being willing to take medication to deal with pain. As she said, still describing her most recent experience of back pain, "The only way I felt OK was lying in bed on my side with my knees bent up-fetal position." Beyond this, she described this most recent experience of back pain, saying, "There was an extra layer of panic to it because of the memory of the pain", referring to the memory of the pain five years previously and once again invoking the fourth theme of the memory of previous experiences of pain adding to the troubling and distressing nature of a later experience of pain. Once again, Jan makes connections between these three experiences of back pain, flowing quickly and spontaneously from one experience to another based on her own associations between experiences of pain. It took considerable concentration, even when re-reading the interview, to determine which of the three experiences of back pain Jan was talking about at any given moment.

Also, for Jan, the memories of these experiences of pain seem to be very vivid. Once again, I was reminded of Bianca's and Luke's comments on their

vivid memories as being memories of events which struck them as very important, but remained detached from any meaning for a long time. These vivid memories of previous experiences seem to be associated with Jan's feelings of foreboding and being out of control. Unlike Cathy and Bianca, her memories did not appear to give her the feeling that this was something which had happened before and, thus, could be understood and dealt with. Recall that both Cathy and Bianca said that previous experiences with pain had given them the sense that they could deal effectively with subsequent experiences of pain. In addition, Cathy and Bianca explained that being able to deal with pain helped them to "move on", as Bianca put it, with their lives. However, Jan does not seem to gain confidence from prior experiences of pain, nor does she seem able to "move on". Jan did not say that she felt that she had gained insight into her experiences of pain. Although Jan talks about discovering that going to a chiropractor can be helpful she does not portray this knowledge as being useful in allaying her feelings of helplessness and lack of control. Jan portrays her earlier experiences of pain as contributing to greater distress when she has experiences pain again.

At this point in the interview, Jan returned to a discussion of the subject of her first Narrative, her most recent experience of back pain, tying this experience of pain to other aspects of her life. Her comments can be viewed as a continuation of the theme of loss of control, foreboding and vigilance. As she put it, "This time, there was an extra stressor". She added,

I found out that I was supposed to take care of a fifteen month old child, who would 'move in for the weekend', just after hearing at work that I was going to be promoted. It would have been wonderful. I just

heard about a promotion at work on Tuesday, [the next day] Wednesday, it [back pain] happened. I was just promoted and I felt like I'd never walk again.

She went on to explain that, because she felt it was important to fulfill family obligations, she pushed herself to be able to care for the fifteen month old. She said, "My husband, who works at home, promised to do all the lifting", in order to help her accommodate this responsibility.

Again, the connections Jan is making are not all revealed or explained to the interviewer. The fifteen month old child is introduced as "an extra stressor". Then the interviewer hears that Jan is pleased that she has received a promotion at work. Next, the interviewer is presented with the information that, even though Jan has been promoted, she feels like she will never walk again, presumably because of the back pain. Finally, Jan introduces the idea of "family obligations", which provides a clue to a possible unifying link. Presumably, Jan feels that she must care for this fifteen month old child because of a family obligation. However, once again, while on close examination it is possible to discern some ways in which Jan is connecting these different aspects of her life, Jan does not make explicit the ways in which she is connecting these experiences. In addition, once again, it seems that the major unifying principle in this segment of Jan's interview is the experience of back pain, in this case the most recent experience. Feelings of foreboding and loss of control can also be inferred from her comments, in which she says "I felt like I'd never walk again." and describes an overall experience of having little control over what happens in her life when she experiences pain.

Jan proceeded to explicitly invoke the theme of loss of control when she went on to describe herself during this most recent experience of back pain, saying, “ I was completely under its control.” Jan followed this statement by saying that she is afraid of pain, adding, “ It is rare to see people in pain”. This last statement is interesting, in that Jan seems to assume that seeing people in pain is a rare experience for everyone, although, quite arguably, it is not. However, Jan immediately went on to explain more about her fear of pain, in general, saying, “ I dread going to the dentist. I even find mammograms painful. Although, when I tried to explain this to the technician, she didn’t believe me”. This series of associations, again, appears to be based on Jan’s associations between experiences of pain, in which she goes from a description of her feeling of loss of control during her most recent experience of back pain to a brief discussion of other experiences of pain, including dental pain and pain experienced during mammograms.

Following this, Jan returned to her discussion of experiences of back pain again, saying, “ I thought I would never get better, that the back pain would continue to recur, that it would always happen again. So I had a bad year”. She seems to be referring to the most recent experience of back pain here, while further developing the themes of loss of control and experience of foreboding. She went on to say that she had also experienced pain in her ankle, stating, “All of these experiences of pain caused me to feel very physically vulnerable”. Again, apparently based on her own subjective experience of pain, Jan has connected a number of experiences of pain, which, for her, coalesce into an

overall feeling of vulnerability. Asked why she felt the way she did about these experiences of pain, Jan returned again to the theme of loss of control, saying, “I felt out of control, panic-y, and I wondered how it would end”. Unlike Cathy and Bianca, Jan does not appear to be able to use prior experiences of pain to help her anticipate what will happen in the future. Jan also commented that she felt she might be responsible, similar to Bianca, saying, “I am aging and very overweight. How responsible am I?”

It is important to point out that, although Jan has offered a great deal of information and discussed many experiences, she is still in an early part of the interview, the Narratives Protocol, which is only the second section of the six section interview. Jan has introduced four themes, great sensitivity to pain, a need to feel in control, experiences of back pain, and the memory of previous painful experiences exacerbating the effects of current experiences. While she does return to these four themes, they seem to serve as less of an organizational structure for the overall interview than the themes introduced by Cathy and Bianca. Unlike Cathy and Bianca, while Jan recalls many circumstances which occur in her life at the same time as the pain, they do not necessarily serve as key organizing principles. This makes it harder to follow what Jan is saying and gives the interview the overall quality of being somewhat scattered, although, upon close examination, it is possible to discern the recurring presence of these four major themes and to speculate on what relation the other experiences she presents have to these four themes.

Also unlike Cathy and Bianca, the experience of a type of pain, back pain, appears to serve as one of the major organizing themes in the interview. Jan appears to connect other life events to her experiences of back pain rather than connecting her experiences of back pain to patterns of life events, as do Cathy and Bianca. In addition, Jan appears to structure her interview based on following these subjective associations, rather than on responding to the overall structure of the interview. Unlike Bianca, who was able to tell a highly individual and personal story while adhering closely to the overall structure of the interview, Jan often does not observe the structure of the interview. This is well illustrated by the portion of the interview during which Jan's story flows so fluidly between her three experiences of back pain that it is sometimes hard to know either which of these three experiences Jan is discussing or which portion of the interview her comments are intended to address.

As mentioned, toward the end of the Narratives section of the interview, Jan talked about another experience of pain, the labor she underwent at the birth of her second child. However, her explanation of the way in which she was able to deal with this experience seems different. In regard to this experience of pain, she said that she was able to adapt a strategy for dealing with the pain. She said that, when the birth of her second child, a son, was approaching, "I developed a mantra. I told myself, 'I wanted this. I planned to do it'," She explained that, "This took the edge off. It helped emotionally, not physically". She went on to explain that she found that it helped to view having this second child as "purposeful. It is to get a baby. It has meaning for me. Meaning and I knew there

would be an end to it". Asked if anyone in her life had dealt with pain in this way, Jan said, "Mother told me as I was growing up", going on to explain that her mother had told her that on the day of her delivery, "When she thought she was going to die, she was given the choice to be put out with 'twilight'". Jan said that her mother told her the people at the hospital suggested it and she thought it was a good idea. Jan added, "Twilight' isn't done anymore". Jan also explained, "My father regards these types of pain as a 'woman thing'", adding, "He can't handle pain, he gets frightened", introducing a theme of gender differences in dealing with pain which she will develop, albeit in a way that is somewhat difficult to follow. It is, also, possible that her ability to attribute meaning to this labor, in which she gave birth to a son, is connected to gender and the higher valuation sometimes accorded to male members of family.

Jan went on to explain that she had a serious post partum reaction to the severity of the pain. Jan seems to have returned to a description of the earlier birth, in which she experienced back labor, without explicitly alerting the interviewer to this change in topic. She repeated that back labor is not common and described it as "unbelievable" and "relentless". Next, Jan returned to the theme of gender issues regarding pain, again, without alerting the interviewer to this shift in topic. She explained that there is an important religious and cultural issue involved. In her community, she said, "Many women, while they are pregnant, swear that they won't have relations with their husbands again". She explained that, while it is uncommon for a wife to actually follow through on such threats and never let her husband touch her again, "Behind this is an experience

of a lack of control". Jan extended this implicit discussion of gender issues further, explaining that she thought that the doctor behaved much like her father. Her interpretation of his behavior was that, since he thought he was harming her, he wouldn't explain to her step by step what was happening to her. Again, it is unclear to which doctor in which experience of pain Jan is referring at this point, but she seems to be saying that male members of her community experience discomfort about pain, perhaps especially unfamiliar forms of "female" pain, and, as a result, are not willing to talk with her about these experiences or help her understand what to anticipate.

Next, Jan began to discuss her need for feeling in control by talking about the way in which she dealt with the threat of Y2K in New York City. This is the point in the interview when Jan brought up this topic. Again, the connection between topics can be followed with an effort, although, at first, the introduction of this subject seems like something of a digression. It is also important to note that we are still in the Narratives section of the interview. I, as the interviewer, was reminded of Jan's concern about being limited to only ten minutes to write her second Narrative. It seems that the structure of this interview is being shaped, to a considerable extent, by Jan's desire to tell her story in a way, and at the length, determined by her. About her behavior in regard to Y2K, Jan said that her husband still jokes about this, saying that he will give away all the bottled water which she stocked up and continues to keep on hand. Because of this, she refuses to tell him where she keeps this "'stash' of bottled water". She described her husband as "not sympathetic" in regard to this issue of Y2K and

stocking up on water. It appears that Jan is further developing the theme of gender issues, here in terms of an overall theme of males not being sympathetic to the concerns of females, or, at least, to her concerns.

Jan went on to explain that, in addition, since 9/11, she is very careful to always keep cash on her and in the house, in case it should be needed for a similar catastrophe. She has also stocked up on emergency supplies, such as duct tape and sheets of plastic. Again, in this sample of New Yorkers, Jan was the only participant to make any extended reference to 9/11 and the only participant to mention Y2K. Unlike the other participants, Jan described herself in regard to Y2K as “out of control”, with a need to “have supplies ready”, while also describing herself as “sad at the need to do this.”

The comparison between Jan and Cathy and Bianca comes into even clearer focus when one considers Jan’s first Drawing. Jan said that she was drawing an experience which took place when she was eleven and half years old. This is interesting, since this is about the same age as Cathy was at the time when the experience she depicted in her second Map occurred.

Jan explained that this experience took place in a big auditorium where she fell and hurt herself during a class trip to a local outdoor area. She was running and she rammed her knee straight into the stage. Unlike Cathy and Bianca, she didn’t remember who was there, although she thought that her friends from school were probably present. Jan said that she couldn’t remember having any broken bones or the necessity for any stitches. However, she described the experience as being “different emotionally”, which seemed to be

an important aspect of this experience for her. Jan also remembered, and emphasized that her father came later. Her father, she recalled, said, “ Don’t worry.”, but, Jan went on to say, “The experience was not like when I was little. It was the most awful experience”. She said that her father brought her to the doctor, and then stayed and “ told his story”. Jan did not elaborate on what her father’s “story” might have been, or on why she found this aspect of the experience so distressing. It was at this point in Jan’s interview that Jan said she was not sure whether she remembers this doctor’s office or has it mixed up with the “office of my son’s orthopedist”. She also said that, from this experience, she learned that “ remediation may really hurt.” Again, Jan does not clearly explain the connections she is making. It does seem that Jan is alluding to the theme of gender, referring once again to men’s lack of ability to deal with and become involved with her experiences of pain. Again, Jan appears to be making associations between painful experiences, which, apparently, are not always clearly differentiated from each other, even for Jan.

However, Jan did explain that she thinks of pain as happening “ More indoors” and that she thinks, “ This experience grew to matter to me only in time as the precedent for my pain experience.” She went on to explain, “ My experience at [name of the outdoor area] was one of the few times I went against authority- and I hurt my knee”. When she got back from this trip, she said that she told herself, “This is what happens when you don’t obey. I think I might have felt more fragile because of the guilt.”, a memorable comment. Like Cathy, although Jan seems to be more overtly aware of the connection of this

experience to her later life, Jan seems to link this experience, which occurred at almost the same age as Cathy's experience in school, to a change in the way she viewed herself and her activities.

Jan added that she doesn't remember what her mother did in this situation and went on to explain that her mother and father were always there to take care of things physically, but not emotionally [her emphasis] . In this regard, Jan's experience seems to be very different from Cathy's and Bianca's, who both mentioned frequently that people in their families were not only available and willing to help with their physical injuries, but were ready to talk with them about their painful experiences. Jan added that her mother did take care of her knee, and that she doesn't remember her mother saying that this was her fault.

Then Jan went on to say that when she was in second grade, she experienced serious cramps and the doctor came. Although she described this as another pivotal experience, she hurried along with the interview, without elaborating further on just what had occurred when the doctor came on this occasion, once again working against the structure of the interview and creating another "gap" in her overall story. However, it seems likely that this experience is related to the theme of gender in regard to pain.

In her comments on her first Map, Jan has introduced a theme of not having family members who were usually willing to talk with her about her experiences of pain. As Jan put it, "If they didn't deem it important, it wasn't expected." It is notable that Jan explicitly states this idea so far along in the interview. However, she does not say that she has just realized this, as some

participants did. For example, Finn and Bob said that now that they had a chance to talk about experiences of pain at length, they had come to realize some things about these experiences which they had not realized before. In earlier portions of her interview, Jan has mentioned some situations, such as her discussion of childbirth with her mother, where some discussion of experiences of pain does seem to have occurred. There is a suggestion of a gender issue regarding who talks about pain and which types of pain are deemed worthy of discussion, by whom. Jan suggests that her mother might have been more willing to talk about “women’s pain”, and, in fact, says that her mother talked with her about labor. Jan also suggests that her mother might have been more sympathetic than her father to her injuring her knee by running into the stage. However, Jan does not pursue these issues. In fact, at this point in the interview, she seems to become uncomfortable, cut her comments on these topics short and curtail any further exploration of these experiences by immediately rushing onto another topic.

Jan was one of three participants who did not do a second Drawing, the point in the interview where several participants, including Cathy, displayed discomfort and seemed to experience difficulty. Paris, the other participant who refused to draw a second Map, explained that he would not do this second drawing because, by this age, pain had become emotional. Jan explained her unwillingness to draw a second Map by saying that from twelve through seventeen, the ages asked about for the second Drawing, “I had become a’ goody goody’ who only sat on the bench, not participating”. She immediately

followed this comment by saying, “This was a normal period. I took care of myself. I was not a ‘risk taker’.” In making these statements, Jan seemed to very briefly introduce the idea that, by this age, she had, indeed, withdrawn from many of her earlier activities, that this withdrawal might be related to her knee injury and that this withdrawal might have been somewhat troubling to her. However, she also appears to immediately refute the possibility that there was any reason to be concerned about her withdrawal.

In the Life Story part of the interview, Jan offered a description of herself which vividly highlighted her difficulties in dealing with pain, saying, “I am not happy to be like this. This is not a pleasant life experience. I have to be ready for it [pain], not rolling with the punches, but forced to be very vigilant”, unlike Cathy and Bianca. Asked if there were any other major experiences of pain in her life which she had not yet mentioned, Jan said that she takes over the counter medications for headaches, including Bayer aspirin, of which she said, “I carry a supply with me at all times.” She said that she suffers from migraine headaches, for which she takes Excedrin, and, in addition, joint pain, for which she takes Advil. She repeated that she is certain to keep the necessary medications always at hand, so that, as Jan put it, “If at all possible, physical pain will not catch me off guard”. Finally Jan concluded her description of herself, saying, “I work my life around pain, the potentiality of pain, the anticipation of it.” She described the ways in which she plans her life around pain. She carries a supply of medications for headaches with her at all times, wherever she goes. In addition, she explained that she carefully plans which of the two or three friends,

all female, with whom she talks about experiences of pain, she will call, rotating them to make sure she does not “over use” any of these relationships. She said that she does this because she does not want to overburden any one friend. She does not want to strain her relationship with any one of these people to whom she can talk about experiences of pain.

To summarize, the tone of the interview with Jan was predominantly one of confusion. Even after the interview concluded, when I was able to examine this interview more closely, the structure of this interview was difficult to discern. On closer examination, it became apparent that Jan’s own statements, very early in the interview, that pain was a very troubling issue for her and that she needed to feel that she was in control, affected both the tone and the structure of the interview. Unlike Cathy and Bianca, who described experiences while they were growing up in which adults were willing and available to not only take care of them physically but also talk with them about their experiences of pain, Jan portrayed her parents as willing to take care of her physically and but as unwilling or unable to talk with her about her experiences of pain. This seems to be especially true of her father, particularly in regard to “ women’s pain.”

While Cathy and Bianca related their painful experiences to larger themes of meaning in their lives, Jan connected painful experiences with each other. At times, she seemed to be unable to distinguish between separate experiences of pain. For example, she blended three different experiences of back pain together, shifting fluidly between them, making it hard for the listener to follow. At times, she said she herself was unsure about which experience she was

describing. While both Cathy and Bianca emphasized that pain was not an especially troubling issue for them, Jan stressed her difficulties in dealing with pain, saying that pain is an extremely troubling issue for her, that she is constantly vigilant, needing to organize her life around dealing with it and controlling it and, poignantly, citing a piece she has read on-line which states, "pain should not be a reason for committing suicide." Unlike Cathy and Bianca, Jan said she has few people with whom she can talk about experiences of pain. She values the few friends she has acquired as an adult with whom she can talk about experiences of pain so highly that she actually plans which of them she can talk with, so they won't feel "overburdened" and refuse to continue speaking with her about painful experiences.

Jan emphasized her need for control. While both Cathy and Bianca were able to fully explain their experiences within the framework provided by the interview without sacrificing any of the individuality of their descriptions, through most of her interview, Jan seemed to need to determine the structure of the interview herself. She objected to the amount of time allocated for writing the two Narratives and developed her story throughout the interview without limiting herself to the topic at hand. However, like both Cathy and Bianca, Jan raised issues which appeared to be related to gender in regard to pain. Like Cathy and Bianca, Jan seemed to be uncomfortable discussing these issues and seemed to avoid pursuing the issues raised by the theme of gender. Jan did this by rushing through her comments when this subject arose, introducing issues, then quickly dropping them. This gave this last section of the interview, in particular, a feeling

of the presence of “holes” or “gaps”. This was similar to the stories related to gender told by Cathy and Bianca, both of whom seemed to leave “holes” or “gaps” in their stories when they discussed gender.

Nevertheless, like Cathy and Bianca, Jan introduced major themes, to which she returned over the course of the interview: 1) that she is unusually sensitive to pain, pain being a particularly troubling issue for her, 2) that she needs to feel in control, 3) the theme of back pain, a particular experience of pain which she finds especially troubling and which she used as an organizing principle for much of her interview, 4) that memories of previous experiences of pain exacerbate the troubling nature of experiences of pain when they occur, 5) that gender issues play a role in Jan’s construction of her experiences of pain, centering around men’s avoidance of “women’s pain” and her experience of limitations on her activities related to gender, and 6) that over the course of her life, particularly since early adolescence, family members have been willing to deal with the physical aspects of her experiences of pain, but not the emotional aspects, resulting in her having few, if any, people with whom she can talk about experiences of pain.

PAIN IN THE LIFE STORIES OF TWO MEN

The interviews with these two men were selected for presentation because they seemed to offer the best opportunity to further investigate major themes which had emerged in the overall content analysis of the interviews with male participants. There were two predominant reasons for selecting Jack’s story

for presentation. First, Jack had provided a particularly rich and interesting description of the syndrome of pain, anxiety and frustration which was discussed by several of the male participants. I was eager to take a closer look at the role this syndrome might play within the context of a male participant's overall story. Second, Jack had said more than most male participants about talking to other people about his experiences of pain. On closer examination, Jack's story helped to illuminate some of the factors involved in male participants' unwillingness to talk about pain with other people.

Finn's story was also selected for presentation for two reasons. First, Finn was one of the three male participants who attempted to adhere to a firm distinction between physical and emotional pain. Of the three male participants who tried to adhere to this distinction, Finn was the one who engaged the researcher in the most extensive discussion of the possibility that physical and emotional pain might not be easy to separate. Secondly, the interview with Finn contained the most dramatic shift in tone of any of the interviews conducted, with either men or women. At one point in the interview with Finn, the atmosphere shifted from being pleasant and gregarious to being tense, almost hostile. This was a startling experience for me, as the researcher, which surprised me and left a profound impression upon me. It seemed important to investigate the role this shift in tone played in Finn's interview.

Jack's Story

Jack was a thirty-three year old man who was living with a female partner in Brooklyn, New York, but was not married (see Table 2). He has an MFA in acting, although he was not working as an actor at the time of the interview. He was working as a field events manager for a food company. He uses a number of forms of alternative health care, including botanicals, which he uses about two to three times per year, occasional massages, about twice a year, and a chiropractor, whom he sees about twice a year. At the time of the interview, he was also seeing a therapist for psychological counseling. He is insured under his job. He had taken antidepressants for about four months, but had been off of them for the three months preceding the interview. He was taking one prescription medication, a cream applied topically for the treatment of cold sores. He also takes over the counter medications as needed, including aspirin, antacids and Claritin for allergies.

The tone of interview with Jack was unusual in that, as the interviewer, I had the sense that I was getting a great deal of very personal and intimate information quite early in the interview. I experienced some concern that it could be somewhat painful to talk about some of this material with a relative stranger, like myself. For example, at the very beginning of the interview, Jack entered into a long, detailed and extremely candid account of his very painful experience of rupturing his Achilles tendon, including some extremely intimate and self-critical evaluations of his own ways of dealing with pain. However, in contrast to this outpouring of information, it also seemed that Jack was working to supply a

good deal of structure in his interview, in the form of a detailed explanatory framework.

Thus, very early in the interview, on one hand, Jack seemed to be almost alarmingly open and willing to talk, while, on the other hand, he seemed to strive to establish a firm structure, which created the impression that he was being rather guarded in his answers. These two factors leant a curious, somewhat contradictory tone to the interview. Despite my overall experience of Jack as someone pleasant and cooperative, I was conscious of experiencing a curious tension. I had a strong impression that Jack was working hard to establish enough structure to provide security and that he was striving to make connections, but then was forcing himself to go beyond this structure to explore experiences and feelings which made him, and sometimes me, uncomfortable. As a result, the tone and the structure of the interview of the interview with Jack were intertwined, reflecting a tension between control and exploration. Jack's efforts to explore were balanced by efforts to pull things together and reconnect them to his central themes, giving a sort of "centripetal" structure to this interview. The final impression that this interview made on me was one of a tight central organizational structure, or matrix, surrounded by a circle of more exploratory attempts, which Jack worked to connect to this central structure.

Similar to Bianca, Jack seemed to use the interview deliberately as an opportunity to explore and take chances. For example, he selected an intimate and painful experience of being sexually molested at the age of eleven for both his second Narrative and his first Map. In addition, as he began his second Map,

he said out loud that he wasn't sure why he had picked this experience, but that he was just going to "go with it and see what happens". Jack also explained, "I never really thought about this before now", leaving open the possibility that he might discover something disturbing while discussing this experience with a virtual stranger, myself. Some of the tension I experienced might well have resulted from my own concern at hearing about so many previously unexamined, deeply personal and painful experiences. However, Jack seemed very willing to take chances in selecting experiences to discuss. As the interview progressed, he appeared to chose experiences for discussion which had been suggested by topics and themes that came up earlier in the interview.

Jack was one of the participants who asked immediately, at the beginning of the interview, whether I meant emotional or physical pain. Told that they were his experiences and he could tell me about what he considered to be his experiences of pain, Jack selected an experience of physical pain, rupturing his Achilles tendon two years previously. He seemed to plunge right into the interview, offering a great deal of very personal information about his experience of rupturing his Achilles tendon, saying,

It was like a gunshot into my calf. I hobbled for three months before I went for help because I had no medical insurance. I was declared medically indigent and got a very good doctor. I ended up getting about \$20,000 worth of treatment.

Immediately following this statement, Jack went on to describe himself and his ways of handling experiences of pain very candidly, including some surprisingly self-critical evaluations of his ways of dealing with pain. As Jack put it,

I am very good at subduing everyday pain. I find a way to dull pain through distraction, orally, or through eating [his emphasis]. My job tends to be isolating. I smoke pot, drink alcohol, it can be daily, usually in the evenings. I depend on this daily maintenance of pain.

With this revealing comment, Jack introduced his first theme, his need to dull and subdue everyday pain through distraction.

Jack went on to discuss what he meant by “ongoing, daily pain” saying, “It’s part of the human experience. I have an average daily level of anxiety, pain and frustration, pretty average experience, I think”. In this statement, Jack connects anxiety, pain and frustration. Still in this early phase of the interview, Jack proceeds to make the powerful reflection on anxiety, pain and frustration cited in the previous chapter, saying that, when he saw what the study was about, while completing the Consent Form, “I immediately thought of breakdown, sobbing, a physical pulling on my chest area because of the release of emotional tension and stored emotional trauma”. With this statement, Jack introduced a second major theme in his interview, a theme of complex relationships between physical and emotional pain.

Jack also explained that, when he saw what the study was about, he wanted to come up with answers before the interview began, confirming my impression that he was striving to establish structure very early in the interview. Jack’s efforts to provide structure in his interview also constitute a theme, although, as the four examples of pain which Jack subsequently provided illustrate, the structure is intimately connected to Jack’s far-ranging and multifaceted exploration of his experiences of pain. Structure and exploration

appear to be related in this interview, operating together as a theme of tension between structure and exploration, rather than functioning as two separate factors. In striving to establish structure in his interview, Jack is typical of the male participants in this study. At some point in the interview, most male participants stated that when they heard what the study was about, they had tried to come up with a plan or a cognitive “strategy” for handling the interview. It seems likely that male participants, who said they were not comfortable talking with others about their experiences of pain, felt it necessary to formulate a plan which would help them remain in control, as a way of dealing with this interview about pain.

Nevertheless, Jack reveals two experiences of emotional pain which he describes as coming immediately to his mind when he heard what the study was about, saying,

The first was in Poland, around 1997. I was twenty-seven years old and went to Auschwitz. I felt I should react with despair for my people, a general human despair. But, when I got to the camp, I felt surprised at the lack of emotional response. It was so overwhelming that my system kind of shut down. I ended up treating it like a museum. Not as intense an emotional response as I expected.

However, Jack went on to explain that he also went to Birkenau where he had another experience of pain, which might be characterized as an experience of collective pain, saying ,

It was not set up like a museum. It is 90% intact. I felt more connection. I dealt with the idea of pain more with empathy and connection to the people there and what they suffered. I left an apple I was carrying. I set

it in a wood shelter where people slept. The idea was to give something to people to whom not much was given except pain and suffering.

Finally, Jack described a fourth experience of pain, which occurred in 1981 when he was eleven years old. Jack is the third of the four participants whose interviews are presented in detail, to comment that something significant involving sex or gender occurred at this age. Jack explained,

I was molested by a family friend... I had an immediate sense that something bad had happened, something emotionally traumatic. I felt I had been used and violated, really violated. The immediate emotional pain was very strong. I found ways to dull that complete pain. I don't really address pain, I try to find ways around it. In the last year, I have been trying to deal with it more honestly, the pain, depression and anxiety. Most pain I feel is pain I inflict on myself.

Thus, at the beginning of the interview, Jack has introduced four personal and powerful experiences of pain: the physical pain resulting from his ruptured Achilles tendon, his two different experiences of pain at Auschwitz and Birkenau, and his experience of being molested by a family friend at the age of eleven. He has also presented the powerful reflection on anxiety, pain and frustration involving "breakdown, sobbing, a physical pulling on my chest area". While talking about these four experiences, he has also made some penetrating, candid and self-critical comments on his own ways of dealing with pain.

At this point, Jack made a discernible effort to pull elements of his experience together, saying,

I was raised in San Francisco in the '70's. There was not much stability, not much support from my family. I was unequipped to care for myself. It is a process. I feel really bad about myself. I try to find ways to understand that kind of behavior, look at and change that kind of thinking.

Here, still quite early in the interview, Jack has introduced the theme of not having support from his family. Unlike Cathy and Bianca, but similar to Jan, Jack presents himself as someone who did not have adults in his life who listened to him when he had experiences of pain. Finally, Jack summarized his discussion of painful experiences up to this point, providing an organizing structure, saying,

There were four distinct moments, four experiences, which sum up my experience of pain, general life, physical experience, emotional experience and an expected emotion which did not occur. This is an umbrella of what I think of as the root of pain and how I experience it in life.

Jack is referring to rupturing his Achilles tendon as the experience of physical pain, his experience of visiting Birkenau as the emotional experience, his visit to Auschwitz as the expected emotional experience which did not occur and the experience of being molested as the life experience. However, Jack does not adhere strictly to this structure as the interview proceeds, but appears to draw on it somewhat loosely to aid him in his efforts to structure the experiences of pain he chooses to explore. It is notable that Jack appears to strive to establish structure, unlike Cathy and Bianca, who appear to be describing life experiences which provide a structure. On the other hand, while Jan struggles to establish structure in her interview, she finds it, in large part, difficult to do so.

For his first Narrative, Jack chose to write about the experience of rupturing his Achilles tendon, an experience which he had identified as an experience of physical pain. Jack stated, “I chose to write about this experience because it embodies a moment in my life when I felt tremendous physical pain. That is one aspect of pain, physical.” Jack explained that the injury to his Achilles tendon occurred two years previously when he was playing basketball with some friends at a public basketball facility in New York City and that he did not immediately take care of what turned out to be a serious injury, saying, “I walked on it for three months. [When I injured it] a friend helped me to the car. I went home and iced it.” It seems that Jack’s behavior in this situation, neglecting this injury for three months, could be regarded as an example of his distracting himself and dulling pain. However, at the time, Jack also explained that he did not have health insurance. He said that, although, as a member of Actor’s Equity, he was able to go to a clinic for a free health consultation, when the doctor told him his Achilles tendon might require an operation, he did nothing further.

Although Jack did not describe how he felt about this experience in his written narrative, when asked, he said, “I felt lucky that I made it through, but it stays with me. I can feel the difference in my two legs. The calf [on the injured leg] is half the size. Now, I would go to the emergency room immediately. I could have avoided all this”. Still talking about how he felt about this experience, Jack talked about how important physical activity and sports are to him, saying,

I still play basketball. It’s important to me. It’s intense, macho and very competitive and aggressive.

I enjoy it and get a distinct feeling. I like sport. I need psychologically to know I can do it. Physically and emotionally, it stays with me, because I can feel the difference. Psychologically, I'm aware before I move of an overall sensation.

With these comments, Jack raises a fourth theme, the importance of physical activity and its complex relationship to his identity and self image.

Asked if anyone in his life had tended to do anything similar to this when they experienced pain, Jack offered a complex answer which further developed this fourth theme of the importance of physical activity and its complex relationship to identity and self image and draws on the two previous themes of the complex relationship between physical and emotional pain and of his need to dull, subdue and avoid pain, which he portrays here as related to the way his mother deals with pain,

My mother. She definitely avoided pain. She used medication as a way to dull pain, both emotional and physical. She doesn't go to the gym, doesn't take care of her body. She's elliptical [sic] of her body. She doesn't feel good about herself. If she cared for herself, she would tend to eat better and release depression and stress. When you allow the cycle of inactivity and depression, it's hard to pull yourself out. You have to take it slowly and do specific things. It's a hard pattern for my mother to break. We talked about going to the gym and not taking drugs. My mother went into Rehab, so she went to the pool.

Jack followed this with a description of his family experience growing up, saying,

My mom was a wild, hippie child. Dad is socially and interactively more subdued. Dad doesn't like to not be in control. They met in the drug counterculture. They divorced. Dad remarried and had three more kids. He's a chef and is on his feet all the time. It's

pretty physical. Mom's boyfriend is overweight and not physically in touch. Mom went to Rehab and now goes to a pool. Mom...She's taken medications and pills her whole life, prescriptions and pot. I went back and forth from my parents. I was raised by both of them.

In these two descriptions, Jack reiterates his sense that the adults in his family were not able to talk with him about his experiences of pain, a fifth theme. He portrays the relationship between physical and emotional pain in his description of his mother, when he says that "she doesn't feel good about herself. If she cared for herself, she would tend to eat better and release depression and stress. When you allow the cycle of inactivity and depression, it's hard to pull yourself out". Jack will go on to describe his own experience of his body when he is inactive in very similar terms.

Finally, Jack explained the dramatic conclusion to his experience of a ruptured Achilles tendon, which occurred after two more months had passed, saying,

I went the welfare route. I went to -----Hospital.-----
 --The tissue was just hanging by a thread. It took six to seven inches of cadaver tendon. They completely cut my Achilles tendon, cleaned it up, and attached the full six to seven inches of cadaver tendon. I could have had a serious infection, lost the leg, death. I was in a cast to the hip. A machine pumped cold water through the cast to keep down the swelling. There was no guarantee it would work. After about two weeks, it looked like there was no danger of infection.

Jack offers a powerful and graphic description of how serious his physical condition had become by the time he obtained treatment. His description

provides convincing evidence for his claim that it is important to him to dull, subdue and avoid pain and that he is “very good at subduing everyday pain” and at finding “a way to dull pain through distraction.”

It was at this point in the interview, while still talking about his first Narrative, that Jack went on to talk about his experience of “anxiety and depression”, related to the “syndrome”, presented in the previous chapter, which was mentioned by several male participants. It is now possible to examine Jack’s description in the context of the statements he made throughout his interview. As Jack put it,

Anxiety, depression it’s like a feeling in the chest. It feels like swirls of tension. And (he points to his chest while saying this) the energy feels bottled. When I exercise, it’s as if I free my body to let go of that-to unwind coils of anxiety, not immediately, but in the long run, it helps. The mind-body connection is so important. I’m sensitive to the physical. When I don’t do it [physical activity], my mental image of my body pulls into my self. When I exercise, I don’t feel the need to pull away from the world. Depression might be physical, one isn’t engaged with life, not doing anything. It is important to exert oneself 100% or I feel inhibited physically. It is a process of forcing myself to go to the gym or run in the park. You have to force yourself to break out of a cycle of trapped forces, force yourself to be active.

Once again, Jack depicts a complex relationship between physical and emotional pain. He also says more about how important physical exercise is to him, the relationship between physical exercise and both physical and emotional pain and the complex relationships between physical activity, identity and self image. In the context of his overall interview, Jack has already explained how important physical activity, particularly basketball, is to him,

saying, 'It's intense, macho and very competitive and aggressive.' He has also said, " I like sport. I need psychologically to know I can do it." a straightforward statement that it is important to his image of himself to know that he can successfully engage in sports. In his previous description, Jack points to the way in which physical and emotional experience are connected, for him, when he explains that "physically and emotionally, it stays with me because I can feel the difference" and "Psychologically, I'm aware before I move of an overall sensation." Jack seems to be saying that the physical and emotional realms are united in an overall sensation which he experiences psychologically and which he gets before he even moves. In the quote above, Jack appears to be saying that when he moves, he feels this connection as a part of knowing that he "can do it", can successfully engage in "intense, macho and very competitive and aggressive" activity. When he does this he "can feel" his image of himself as good and successful.

In the quote above, Jack also explains that, when he does not engage in such intense physical activity, his experience is that " my mental image of myself pulls into my self." However, with the improved sense of himself which even the prospect of intense exercise provides he says, " When I exercise, I don't feel the need to pull away from the world." It seems that being able to view himself as someone who can successfully engage in vigorous and competitive athletic activity provides him with a self-image which makes him more comfortable in facing the world. He concludes by saying, "You have to force yourself to break out of a cycle of trapped forces. Force yourself to be active.", summarizing his

deeply felt conviction that intense, competitive activity is essential to maintaining a positive sense of self and a resultant feeling of overall well-being.

Like Jan, Jack is using experiences of pain to organize his interview, although he appears to be midway between Jan and the position taken by Cathy and Bianca. He is able to organize his experience and, to some extent, to form connections between experiences, although he seems to struggle to form these connections.

Consistent with his willingness to explore, Jack investigated his painful experience of being molested by a family friend in both his second Narrative and his first Map. This experience appears to remain extremely painful and to continue to occupy a central position in Jack's life, as Jack explained while talking about his first Narrative, saying, "This was one of the most intense emotional moments of pain, a memory throughout life." Jack described the family friend, J, the man who molested him, as "a child in adult's clothing. He was a D.J, on the fringe, not a responsible adult. His family were very rural, simple people.", again, depicting adults in his life as unable to talk with him and offer him support because they are unable to deal with their own experiences. Jack began to establish connections between this experience and a more general, overall pattern in his life, saying, " There is a common thread, a sense of avoidance, which takes on an immature sense of a child not doing his homework, a child in adult's clothing." Jack immediately goes on to connect this to his own upbringing, saying, "There was not a lot of structure, nurturing or togetherness [in my family]. It hurt me, the isolation and the time away from people." Here, Jack

is further developing his fifth theme, the theme of not being able to depend on the adults in his life while he was growing up. Thinking back to what he said about his family in his comments on his first Narrative, such as, “ I went back and forth from my parents. I was raised by both of them”, and “My mom was a wild, hippie child. Dad is socially and interactively more subdued. Dad doesn’t like to not be in control. They met in the drug counterculture. They divorced. Dad remarried and had three more kids”, it appears that, in saying “ there is a common thread, a sense of avoidance” he is beginning to form a connection between this fifth theme of not being able to depend on adults in his life and his first theme of using avoidance to subdue everyday pain.

Continuing to talk about his experience of being molested by this family friend while drawing his first Map, Jack also began to develop a sixth theme of place and its relation to painful life experiences, saying “This is a place in my mind that I don’t want to go to. A place associated with pain, depression and not feeling competent”. Taken together with Jack’s statement, “There was not a lot of structure, nurturing or togetherness [in my family]. It hurt me, the isolation and the time away from people.” sheds light on the connections Jack is making between place and pain. It appears that, for Jack, his feelings of isolation are connected to places. The distinction between a “place in my mind” and a physical place is not absolute. Still talking about his first Map, Jack drew a Christmas tree and a couch, saying, “It was a long walk down the hallway to the bedroom. I remember being without food and finding a piece of fruit in the tree”, a reference to a lack of nutrition which echoes his comments, earlier in the

interview, when he explained his empathic reaction to what had occurred at Birkenau. He described this bedroom, saying, “It was foreign dark, isolated and depressing”, further developing the theme of places in his life in which he experienced isolation and depression. It was surprising to hear a participant in this study describe a place where he had a painful life experience when he was ages six through eleven in negative terms. Most participants said that their experiences of pain when they were in this age range occurred in places which they liked, places in which they also had many pleasant experiences.

Asked whether he could explain why this happened, Jack said, “ Because he has got a sickness, a problem, he never addressed. For whatever reasons, he never sought treatment and wound up inflicting pain on others. He inflicted pain on me. He has given me a lifetime of pain.” Jack added, “I still harbor resentment because this man has an attraction to children. It didn’t just happen with me. After me, I understand he did it again. This man has the potential for extreme violation”. Jack went on to say, “ This experience mattered in my life, yes, really negatively. It established a system of handling pain in my life.” developing further his first theme of his need to dull, subdue and avoid pain, which appears to have multiple roots in his life.

Asked if this was a place where he was likely to experience pain in his life, Jack returned to and further developed his sixth theme of places and pain, elaborating on the relation between physical experiences of isolation and depression. As Jack expressed it,

No, but I do have an association with seduction. An almost rural setting. The house was in a bleak,

desolate area, an isolated and desolate home, very simple. With this comes a feeling of depression as part of a mental image. I have a fearful image I'll end up as a born again Christian or fundamentalist in a trailer park home. I'll give up on a life of achievement and my professional goals will fall away. I'll be bleary, void of feeling, very numb, a sort of caretaker state, a mental image of shutting down. Asked whether this could have happened anywhere else, Jack replied, Umm, Yeah. It could have happened at my parents'. But the experience is universal. It could happen anywhere. I found this out from a friend and it started the process of healing. This happens to one in three women and one in seven boys. This was a big relief. I could exhale after one and half years. This could happen to anyone, anywhere. Molesters are people who are molested. It was a comfort to hear someone's experience that was more detailed and involved oral copulation. I didn't have it as bad as someone else.

Jack appears to be raising a seventh theme, of finding it helpful and healing to able to share experiences of pain with people who have had similar experiences.

Jack further developed this seventh theme, explaining that he had taken a course in college in which a class assignment had been, "to write a ten page term paper on any topic, but, to write about the experience in as much detail as possible, from the first moment, from beginning to end. This really helped. It was the first time I did this as an adult." Jack added that, although he did talk to his mom about this, "I didn't really talk about feelings, the pain of the experience." Here, it seems that Jack is referring back to his earlier theme of not being able to depend on or talk with adults in life while growing up while further developing the theme of finding it helpful and healing to able to share feelings with people who have had similar experiences. Apparently, while his mother was willing to listen to him, she was not able to provide the needed confirmation of his

feelings which he experienced while talking with his friend and writing about his experience for the class assignment in college. Jack seems similar to Jan in that he describes himself as coming from a home in which adults were not available to talk with him about his experiences of pain, although they were willing to take care of his injuries. Like Jan, as an adult, he has found people with whom he can talk about his experiences of pain. However, Jack seems to have discovered more opportunities than Jan to discuss painful experiences with others who can provide the element of sharing which he did not experience as a child growing up.

Asked if there were any major experiences of pain in his life that he had not mentioned, Jack developed the theme of being able to share experiences further, adding,

Interesting, a painful moment. My grandfather died, four or five years ago. I saw his body. At the funeral, I spoke for my generation. There was shock and pain, then relief. The pain wasn't there. In the pulpit, I felt relief, the pain had lifted.

This is the third example Jack has offered of a situation in which he was able to share his feelings about a painful experience with others. As in the previous two examples, Jack says that he found it helpful and healing to be able to share these feelings with others who have had similar experiences, further developing his seventh theme of the healing effects of being able to talk or write about painful experiences and share these experiences with others.

In his discussion of his second Map, Jack further developed the theme of place and pain and of his experience of isolation which fostered feelings of

depression. Once again, Jack presents themes of isolation and lack of nurturance connected to the physical environment. He also portrays an additional experience of an adult who was not able to listen to his experience. He began his second Map by drawing a series of houses in rows. Asked what the place was like, he said,

Lots of places, close together. Very middle class. Not much entertainment. Not much transportation. San Francisco is not a huge valley town. In California, everyone drives. We lived here (as Jack says this, he marks the house). It was isolating, removed. It was an effort to go anywhere. It was isolating and concrete. The front was all landfill. It was sandy and hard to grow things. The blue sailboat, little green person, that's me! My stepmother's father, E, was very strong, a famous pro- football player, an athlete, unhappy with his own life. He was an odd figure in my adolescent life. We were related by marriage. I was around fourteen or fifteen and was just cut from the Freshman football team, a very powerful experience. This was the "Sunset District" with very middle class housing. We walked to the store. He asked who I liked better, my mom or my dad. It was an odd, negative experience. An adult put you in an awkward position. I don't know exactly, only it was meaningful and painful. The question made me angry and uncomfortable, and I was put in this position by an adult.

In this description of his second Map, Jack draws on and further develops his seventh theme of place and pain, and his association of places with his experiences of isolation and depression. In his description of his second Map, he connects this experience of isolation to a lack of growth, which, in turn, he connects to his fifth theme of not having adults in his life on whom he can count. In addition, his final comments tie in the third theme of the tension between

exploration and an effort to provide structure. When he says, “I don’t know exactly, only it was meaningful and painful”, he demonstrates his willingness to explore, while the overall nature of this description demonstrates Jack’s efforts to form connections between the themes he has addressed in his interview.

Jack added to this story, saying that a couple of years later, E committed suicide. When I asked if E knew that Jack had been cut from the football team, Jack answered that E did know this, adding,

He was reluctant to give advice. He was a negative person. It was difficult to be around him. He wasn’t a nurturing or supportive person. That was MY experience of him. Maybe HE didn’t feel close to people. An adult, so remote and removed, a cold, odd question. I felt put on the spot, a negative person pouring negativity on me.

In these comments, Jack is further developing the two themes of not being able to depend on adults in his life for nurturance and growth and experiencing isolation and depression.

Jack’s experience of isolation extended even to his experience of this walk. Asked if there were other places involved, Jack replied, “ No. On the walk we were isolated.” Asked if this experience mattered to him, Jack again displayed his willingness to explore in this interview, saying, “It is not one I picked out. It has to do with the residual effects of how I deal with some situations. When I feel manipulated, I freeze up. Instead of just saying, ‘Sorry, that’s inappropriate. “ With this comment, Jack added to his drawing, indicating that the boat was near the ocean. During the interview, it did not occur to me that this addition to his drawing might carry meaning. However, as I write this in the

context of my own, ongoing analysis of the themes and content of this interview, it seems quite possible that Jack was forming a connection between the formerly isolated, little green figure of himself in the small blue boat and the larger world of the ocean. It seems conceivable that Jack, through talking about his painful experiences, striving to form and explore connections between issues in his life, and, possibly, sharing these experiences and connections with me, as the interviewer, was beginning to experience more of a feeling of connection, causing him to add to his drawing in a way which reflected this experience of relationship and sharing.

Jack went on to elaborate on the theme of place and pain, explaining that he associates the place he has depicted with “some sort of depression. It’s isolated, a ‘cookie cutter life’. Everyone’s the same, looks the same. Life is a boring cycle, lived in an isolated shell”. Asked if he notices in his stories and drawings that certain types of people are present, Jack replied, “ Negative people, overtly negative and unhappy. I have a low tolerance [for that kind of people], not bitter, like that. This guy was very up front about his unhappiness, blunt and pointblank.” Asked if these were the types of people who were usually present when such things occurred in his life, Jack said, “Yeah, bitter and manipulative. They put me in an awkward position. People in my life were very often more irresponsible, a different type that concealed their unhappiness, people lost, irresponsible, using alcohol. Adults weren’t able to be there for me. As a child, I was molested. As an adolescent, this was reinforced. Adults were just as fucked up, just as unhappy.” Asked if he thinks this could have happened

anywhere else, Jack replied, “Yeah, as long as I was isolated from others. No stores, no restaurants, just long rows, all alphabetical, Ortega, Quintero, Grocery stores were all ethnic, no 7/11, there was an old Russian bakery”. With these comments, Jack seems to be connecting several themes, his first theme of dulling and avoidance as a ways of dealing with pain, the theme of not being able to depend on the adults in his life while he was growing up; and the theme of place and pain being associated with isolation and depression. Moreover, Jack seems to be accentuating the theme of not being able to depend on adults, building it up as a more central theme around which he can organize some of the other themes he has raised in his interview.

Finally, when viewed within the context of Jack’s overall story, Jack’s interview offers insights into the male participants’ claims that they preferred not to talk to other people about pain. When the subject of talking to others about experiences of pain first came up in Jack’s interview, I was surprised because Jack began by saying that he did talk to other people about his experiences of pain, mostly to his live in female partner and to his female therapist. This was an unusual response from a male participant. However, as Jack continued to discuss talking to other people about his experiences of pain, his comments resembled those of the majority of male participants. Jack immediately went on to qualify his apparent eagerness to talk about experiences of pain, saying,

I do this almost to a fault. I share feelings, but still not beyond a certain level. It’s so emotionally overwhelming, so present, unsurfaced [sic] that I almost want to back away. Emotional pain is scary to feel. I feel like I almost can’t function. But, it has adverse effects to hold onto and hide pain.

Physically, your body reflects pain you hide. I rotate my thighs in, makes me pigeon toed, because I was molested, sexually attacked, I try to keep my groin area protected. This is me physically protecting myself from experiencing pain. I physically manifest most pain.

Here Jack is offering a possible explanation for his portrayal of pain as a complex relation between the physical and emotional, the second theme which he raises in his interview. Similar to other men in this study, Jack states himself that he is not comfortable connecting physical pain to emotional pain. As he puts it, “It’s so emotionally overwhelming, so present, unsurfaced, that I almost want to back away.” Jack offers a vivid explanation of how uncomfortable he feels about emotional pain when he says, “Emotional pain is scary to feel. I feel like I almost can’t function.” As Jack went on to explain, “I have different levels of communication with different people. I talk really deeply about my experiences of pain to my therapist”. Jack also emphasized that the way he likes to be treated is to be heard and understood, not told what to do to “fix it”. The statement is reminiscent of the interviews with the three female participants, particularly of Jan saying that her family could be counted upon to “fix” any injuries she sustained, but not to talk with her about the her feelings.

When asked how many people he can count on to help him when he experiences pain, Jack said that he counts his partner and his mom as “automatics”. However, he does not count his therapist, because she is an “outsider”. Again, his comments are reminiscent of Jan’s. Like Jan, he portrays himself as being very aware of just who the people in his life are with whom he

can freely communicate about all aspects of his experiences of pain. Like Jan, he seems to feel that there are very few such people in his life. Jack went on to explain that he has a network of a lot of friends, about seven or nine of them. However, he described the way in which he connects with these friends, all other men, saying, “ We smoke pot, the way we’re connected. They will try to talk on the phone, mostly. But we are likely to get together by engaging in a common activity.”

Jack also talked about the pain of breaking up with his partner one year ago. It was not until I considered what Jack said about this topic in the context of his overall story that I realized that several of the male participants, including Paris, Luke and Finn, had talked about the pain of break ups with partners. However, they did not elaborate on this topic beyond saying that these were painful experiences. Jack explained that he and his female partner had broken up but had, subsequently, been reunited and have been back together for six months. He described this reunion as “A cathartic release of the special pain I brought into the relationship versus the pain of the breakup which opened the floodgates.”

To summarize, the tone and the structure of the interview with Jack seemed to be intertwined. It seemed that Jack was striving to maintain control by constructing a tight, central organization in his interview while, at the same time, he was endeavoring to explore, appearing to boldly take chances and select very intimate experiences of pain to discuss. This gave the interview with Jack the startling, but interesting, quality of being both very controlled and boldly

exploratory. Jack was similar to Jan in seeming to experience a need to control the structure of the interview. However, after his rather controlled beginning, he seemed more willing than Jan to take chances and explore feelings and experiences which might surprise him. Over the course of the interview, similar to Cathy and Bianca, Jack developed major themes, exploring and elaborating upon these themes as the interview progressed. In addition, Jack introduced some important new themes rather late in the interview. Finally, during the repeated reviews of all the interviews which were necessary for this analysis, I realized that the structure of this interview, with its tight, central organization surrounded by efforts to explore resembled the structure of the interview with Julie. Jack and Julie were the only two research participants who reported being actively involved in therapy at the time of the interview. Jack was working with a psychotherapist. Julie was regularly attending meetings of Alanon, an organization established for relatives of alcoholics, and had an Alanon sponsor.

Jack's attempt to establish a structure as a strategy for dealing with this interview was something that many of the male participants seemed to do. Looking back at the order in which themes were raised in this interview, it is interesting to note that Jack begins by talking about his experience at Auschwitz. He says that he was unable to experience a feeling of connection there, although, at Birkenau, where the environment had been kept "90% intact", he was able to experience the feeling of connection with the experience of the people interned there that he was seeking. Moreover, at Birkenau, he felt he was even able to offer nourishment to the people who had suffered there, by leaving

an apple. This desire to connect with others and a view of the environment as isolating prove to be important themes which Jack is able to connect over the course of the interview. Although this quote comes from a very early portion of the interview, it is related to the seventh theme, that it is helpful and healing to be able to share feelings and experiences of pain with people who have had similar experiences. In this later part of the interview, Jack talked about being able to experience a sense of connection and explained how helpful and healing he has found experiences such as talking to a friend who had also been molested, writing about his painful experience of being molested for a class and speaking for his generation at his grandfather's memorial service, which allowed him to share the pain of the loss of his grandfather with others. It appears that Jack has been able to use the interview to work between structure and exploration, developing themes and forming connections which have helped him to build on the seventh theme of the healing offered by situations in which he can connect and share his feelings with others. Jack appears to make an effort, periodically, to integrate the experiences he is exploring with major themes which link them to the experiences he has already discussed, maintaining connections between earlier themes and later themes. Jack returns to this important and hopeful seventh theme more and more frequently toward the end of the interview. These observations reinforced my initial, strong impression that Jack was striving to make connections between his experiences and to find meaning in these experiences, using a tight central structure surrounded by bold exploratory attempts.

Jack brought up seven major themes: 1) the need to dull, subdue and avoid everyday pain, often through distraction, which he introduced as a family pattern, saying that his mother tries to ignore pain and dull the sensation, often through the use of medication, 2) a complex pattern of relations between physical and emotional pain, 3) the tension between structure and exploration in Jack's interview was so pervasive that emerged as a theme, 4) the importance of physical activity and its complex relationships to identity and self image, 5) not being able to depend on adults in his life while growing up and not being able to talk to the adults in his life about his experiences of pain or speak about his feelings, which he described as contributing to a feeling of isolation, 6) the relationship between place and pain, with places often being associated with isolation and depression, and a final, seventh theme, which began to emerge more strongly toward the end of the interview, 7) that it is helpful and healing to be able to share feelings and experiences of pain with people who have had similar experiences.

Finn's Story

Finn was a thirty-six year old single man born and raised in Amherst, Massachusetts, who was living in Brooklyn, New York (see Table 2). At the time of the interview, Finn already held a Bachelor's degree and was working on a Master's degree while running a language lab at a local college. He said that he obtains his health insurance, which he considers very good, through his employment. Finn stated adamantly that he never takes any type of medication,

saying, “None. No. Never. Not even Tylenol.” Finn also said that he doesn’t use any forms of alternative health care.

There were two aspects to the tone of the interview with Finn which impressed me and made the interview with Finn one of the most striking interviews I conducted for this study. First, Finn described the experiences of pain he has encountered during his life in a very casual, even offhand, manner. Because of this light tone, as the interview progressed, I found myself feeling somewhat perplexed about just how serious the injuries Finn was describing in his two Narratives and first Map might have been. I began to feel more and more certain that there was a discrepancy between the casual manner in which he discussed these injuries and the actual seriousness of the injuries. By the time Finn drew his second Map, portraying a scene in which he fell while skateboarding down a very steep hill, his description, “ I sort of left a lot of skin on the hill”, made me realize that the injuries he was describing had probably been more severe than I had at first realized. For example, he began his description of the injury he chose to write about in his first Narrative, when he hurt himself while trying to put out a fire with his bare hands, saying, “I put it out [the fire]. Then I put my hands in water-ice water. My friend got a bowl of ice water. When my mother came, she took me to the doctor. I wouldn’t have gone on my own”. This description seems to suggest that his injuries were relatively minor, since he portrays the decision to call a doctor as a judgment call. However, when I finally asked him, in order to clarify my own understanding of

what had occurred, how long it had been before he was able to use his hands as usual, Finn replied, still quite nonchalantly,

Two to two and a half months. My hands were bandaged for two to two and a half months. It affected my life in regard to showers. I had to wear plastic bags. My hands were raw for a while, about three weeks.

This was the point in the interview where I realized that the casual tone in which Finn discussed these experiences might be misleading and that Finn might have a strong tendency to minimize the extent of his injuries.

Second, while Finn was talking about his first Map, an abrupt shift in the tone of the interview took place, a shift in tone so noticeable that I made a notation about it on the interview form. This striking change in tone was one of the reasons why Finn's interview was selected for presentation in this chapter. This interview began in an affable, friendly way. Finn seemed to be a very nice, polite, engaging man who had been accommodating enough to become involved in this research project at the suggestion of his friend. However, while Finn was drawing his first Map, a depiction of his experience of injuring his hand at the age of five, almost six, while playing in the wheel well of a truck in a lot near his family's home, I became aware of a dramatic change in the atmosphere of the interview. I found myself having a very difficult time focusing my attention on what Finn was saying and suddenly experienced a feeling of profound lassitude. This startled me because, since Finn was one of the last participants to be interviewed, I had already conducted fifteen of the nineteen interviews and I had not previously experienced any such feelings or shifts in tone, even though many

of the interviews were quite long, some lasting more than four and a half hours. Next, I became aware of an atmosphere of discomfort, almost of hostility.

On reflection, I think there was an abrupt disconnection in communication between Finn and myself. This surprising and dramatic shift in tone only lasted for a few minutes. By the time Finn had begun drawing his second Map, of his experience skateboarding down the very steep hill, the tone of the interview was once again friendly. In addition, Finn seemed to become even more engaged in the discussion of his experiences of pain than he had been at the beginning of the interview. He began volunteering information about how surprised he was at some of the discoveries he had made during the course of the interview, particularly regarding two issues. To begin with, he said he was surprised by the possibility that he had deep, previously unexplored feelings about some of the experiences he discussed during the interview, such as the consequences of his not receiving care sooner when he became ill during his visit to his grandparents island summer home. He also said he was surprised to discover that he was not able to maintain a sharp distinction between physical and emotional pain.

Writing about the tone of this interview has been helpful to me in trying to explain the structure of the interview, since, on reflection, I realized that the tone and structure of this interview were intimately interconnected. This interview actually appears to have two parts, a “before” and “after”, with the bifurcation between the two sections of the interview marked by the change in tone. Before the change in tone occurred, Finn appeared to be politely trying to supply the kinds of information he was being asked about in the interview. After the change

in tone, Finn became very involved in the topic of his experiences of pain and seemed to actively draw upon the opportunities offered by the interview to discuss and examine these experiences. Remarkably, within the context of the interview, Finn seemed to face some painful experiences in his life and, to some extent, reevaluate them. In the later part of the interview, Finn chose to become actively involved in reconsidering his view of the painful experiences he had selected for discussion in his interview.

For his first Narrative, Finn chose to write about an experience which occurred when he was about sixteen or seventeen years old. He had been out shopping in order to pick up some refreshments for friends, who were visiting him in his mother's house. His mother was out at the time, but the friends had already arrived and had gathered in his bedroom. Finn explained that, when he entered his bedroom, he realized that the window curtains were on fire. He said that he responded to this emergency by grabbing the blazing curtains with his bare hands in an effort to put out the fire. He commented that he chose to write about this experience of pain because it was the first one that came to his mind and because he thought it was an interesting story and it seemed like a "salient example of pain". Both Finn's understated description of this experience of pain and his stated strategy of selecting an experience of pain which seemed to fit the practical and functional requirements of what was being asked about in the interview illustrate the first theme which arose in this interview, a theme of adopting a rational, logical and sensible stance toward the interview. This is not unlike Jack's initial position of trying to establish a rational, objective central

structure for his interview. Like Jack, who stated early in his interview that when he saw the subject of the interview he wanted to come up with answers before the interview began, Finn appears to have tried to establish a sort of “rational game plan” for dealing with the interview. Many of the male participants appeared, initially, to try to establish such a stance toward the interview.

As we talked about this experience, Finn began to speculate on whether he might have been able to do something more moderate than grasping the flaming curtains with his bare hands. He described making the decision about what to do, saying,

It was surreal. I was worried. The decision was so quick to deal with the situation this way. There might have been something else to do...It may not have been the best decision. But, the apartment was on fire. I needed to do something. It needed quick action. Afterward, I might have regretted this course of action because it was really painful, really bad burns. I thought I might lose the fingernails on my ring or middle fingers. I had a bad burn around my thumb.

Here, in reflecting on this experience, Finn is beginning to formulate a second theme, a theme of feeling responsible and having to manage things on his own.

At the same time, Finn also appears to begin to question his need to assume responsibility and to consider the possibility that others might not be taking enough responsibility. Immediately after making the statement above, Finn said,

My two friends didn't notice and stop it. It all happened so fast. My friends might not have known. If-then—I was confronted with the fire and had to make a decision.

In saying this, Finn seems to begin to entertain the idea that he might be able to take better care of himself and that his friends might not have done all that they could, since they were there when the fire broke out and, very likely, had done something to cause the fire. These reflections will continue, emerging as a third theme, that of questioning whether he might be able to take better care of himself and whether others, as well, might be able to be more caring in their treatment of him. When Finn said, “Afterward, I might have regretted this course of action because it was really painful, really bad burns. I thought I might lose the fingernails on my ring or middle fingers. I had a bad burn around my thumb.”, his tone of voice did not change. This offers an excellent example of Finn’s tendency to minimize and underestimate the seriousness of his experiences of pain, which, with this statement, first emerges clearly as a fourth theme. It was this statement which prompted me to ask him just how seriously injured he had been as a result of putting out this fire. Finn replied that he had not been able to use his hands normally for two to two and a half months.

At this point, Finn commented, “I just dealt with it” which seemed to serve as his summary of the way he usually handles his experiences of pain., consistent with the theme of feeling responsible and having to manage things on his own. Finn said that this was also the way other members of his family deal with experiences of pain, particularly his mother and brother. As Finn said,

Probably. Yeah. My mom and my brother. I know my brother always denies he’s in any pain, whenever possible. My mom, if she experiences pain, she probably didn’t [sic] want to burden us kids. So, she was stoic, maybe a little extreme, a little more. Both just deal and work, get through it.

This statement is also a further development of the first theme, of taking a rational, objective stance.

For his second Narrative, Finn chose to write about his experience of becoming sick, when he was about twelve years old, with a bad case of strep throat while visiting his grandparents at their summer home on an island in Canada. Finn said that he chose this memory because, “I got sick. I have a really clear memory, really vivid memory. I remember being really feverish. And, because I thought it was really a better example of a memory of pain” than his first Narrative, the experience of burning his hands. His comment that this memory seems to be “really a better example of a memory of pain” seems to relate to the first theme, of taking a rational objective stance. He commented further, saying about his memories of other experiences of pain, “I remember they were painful but it is more abstract”. However, about this experience of pain, he said,

I remember the experience of extreme pain. I'm not sure I remember the actual sensation, or if the memory or circumstances combine for a more vivid memory of pain- the details that surround it. For example, when I had my wisdom teeth extracted, it was not so real as being painful. It was more abstract. Also, the situation. I knew it was coming.

Finn explained that there were no doctors on the small, rural island in Canada where his grandparents' summer home was located. In order to see a doctor, one had to go to the mainland. However, there were telephones on the island, which could have been used to call a doctor. Nevertheless, his grandparents did not consult a doctor for quite a while and Finn became even

more ill. Finn explained that his throat became so sore and swollen that he was unable to swallow and his grandparents had to place a bucket next to his bed into which he could spit. Finally, his condition became so serious that they took him to the mainland, where he was treated by a doctor.

At this point in the interview, Finn did not appear to question the wisdom of this course of action on the part of his grandparents. He maintained that this could have happened to anyone, it was just bad luck on his part that he had become so sick while visiting an island where there were no doctors. Asked how he felt about this experience, Finn replied,

Bad luck. Bad timing. Wrong space. If I was in the “normal environment”, it would have been caught much sooner, before it “dominoed” into other things.” “In our family, in general, we try not to hold anyone else responsible for our pain, ill luck. Unless I’m beaten up for no reason.

This quote offers further examples of the first two themes, the first theme of adopting a rational, logical and sensible stance toward the interview and the second theme of feeling responsible and having to manage things on his own. However, in Finn’s subsequent comments, he returns to and begins to elaborate on the third theme, questioning both whether he might be able to take better care of himself and whether others might be able to be more caring in their treatment of him.

As Finn went on to explain more about this experience, he appeared to be giving further consideration to both possibilities, that he might be able to take better care of himself and that others might be more caring in their treatment of him. Finn began by saying,

It was my bad luck. I felt a little bad at this happening. I don't think I blamed a specific person. I just thought, 'Why has fate done this to me?' There's got to be some glimmer of self pity, more at the time. It stunted my puberty. For the whole next year. I probably didn't really get into adolescent changes until I was over fourteen. Everything was stunted. My brother is the same height as I am, but weighs fifty pounds more. I feel self pity. It was hard not to be in school. I had a private tutor for several months.

This quote serves two purposes. The beginning is a very good example of the way Finn began talking about the experiences of pain he chose to discuss in this interview, employing the first theme, of adopting a rational, sensible approach toward the topic of the interview and the fourth theme, of the tendency to minimize the severity of his experiences. However, within this quote, one also can see Finn's view of this painful experience shifting. While he begins by saying that he thinks this experience occurred simply due to bad luck, he goes on to reveal deep feelings of hurt. At first, he minimizes these hurt feelings, saying, "There's got to be some glimmer of self pity." However, he immediately goes on to say, "More, at the time." and proceeds to make the much more powerful observations that, "It stunted my puberty" and "Everything was stunted."

My reaction to these statements was similar to my feelings when I realized that Finn, in the experience he described in his first Narrative, had injured his hands much more seriously than I had at first comprehended. At first, I was rather perplexed by his description of this experience. As I heard more about it, I became increasingly surprised that Finn's grandparents hadn't tried to obtain medical assistance sooner. As Finn's story unfolded, it appeared that he had

been seriously ill and in severe pain, with a throat so swollen and sore that he was unable to swallow and had to spit into a bucket placed near his bed. Yet, his grandparents still had not felt that his condition merited professional medical attention. Moreover, like the resulting injury to his hands, which left him unable to use his hands normally for two to two and a half months, this illness seemed to have resulted in Finn's being unable to resume normal life activities for some time after. In this case, Finn wasn't able to attend school for several months. Finally, at least in Finn's estimation, this illness had eventually become so severe that it had interfered with normal growth during his early teenage years.

For his first Map, Finn depicted an experience which occurred when he was about five or six years old. He was playing in the wheel well of a truck in a parking lot near his family's home, a favorite place to play. When he returned home, he noticed that he had a "bloody mitten". As he explained, "I took off the mitten and started crying. My mother was there. Yeah. There was no one else there. I think she said, 'What happened?' When I told her, she said, 'We are going to the doctor.'" As Finn told more of this story, it became evident that he had, once again, understated the extent of his injuries. He described the state of his hand when the bloody mitten was removed, saying, "Yeah. [There was] a pretty big flap [of skin]. A good portion of the top part of my finger."

Finn offered another reflection on pain and memory, to explain the significance of this experience in his life, saying,

No, not really. But, I do remember it. It's just what I thought of. Probably everyone of these stories are stories I remember and also Mom remembers and we have talked about since. But, certainly, not

often. Occasionally, when we reminisce. These are not even family stories. No. They just happen to come up when something else around that time is being discussed-same kind of story-the T-ball team I was on or something. I can't remember the last time I talked about something like this-three times since then. Mom remembers and tells the story. It's partly memory, partly Mom's story.

With this, second, reflection on pain and memory, it became apparent that Finn's reflections on the relations between the actual experiences of pain and his memories of these experiences constituted another theme in Finn's interview.

It was at about this point in the interview that Finn's attitude seemed to change dramatically. At the time, I was profoundly struck by the sudden change in the tone of the interview, although I wasn't sure what was taking place. Looking back at the entire interview, it seems likely that Finn was continuing to reflect on the experiences he wrote about in his first and second Narratives, particularly his experience with having a severe case of strep throat while visiting his grandparents. It appears likely that, due to recounting and reflecting on these two experiences, Finn was beginning to think more critically about his attitudes toward pain and the way others behaved in these two situations, resulting in the emergence of a sixth theme, a theme of beginning to re-examine his experiences and ways of dealing with pain.

For his second Map, Finn chose to depict a scene in which he was trying to skateboard down a very steep hill. After a brief pause during which he tried to think of an experience which had occurred when he was in the specified age range, he began to draw. He explained the scene, as he drew, saying,

Oh. I remember one thing. I was skateboarding down a really, really steep hill. I was wearing a backwards baseball cap (said as he draws this cap on his head). And, I fell really badly. It was because I was going really fast. And, then, I, yeah, I scraped a bunch of skin off my back. I sort of left a lot of skin on the hill. I was with a couple of people who were better at it than I was. My friends said, 'Are you OK?' I didn't go to a hospital. I probably didn't need to go to a hospital. I got the gravel out of my skin. It took about two hours. The scrapes were bad.

In his description of this experience, Finn draws on the second theme, of feeling that he must take responsibility and manage on his own. However, when he comments, "I didn't go to a hospital. I probably didn't need to go to a hospital.", Finn seems to be developing the third theme in his interview, his dawning awareness of the possibility that he, and others, might be able to take care of him better. His comments also exhibit a growing awareness of the fourth theme, his tendency to minimize and underestimate the seriousness and extent of his injuries and experiences of pain. He admits that "I fell really badly" and he describes his injuries as severe, saying, "And, then, I, yeah, I scraped a bunch of skin off my back. I sort of left a lot of skin on the hill." and, "I got the gravel out of my skin. It took about two hours.", finally admitting, "The scrapes were bad." Moreover, Finn went on to explain, "They brought me to one of their houses. They lived closer. They gave me hydrocortisone. The guy tried to get as much gravel as possible out. The girl was a little skittish. My back was really skinned." These further comments seem to address the theme of questioning whether he and others might be able to take better care of him. In this case, his friends, or at least his male friend, seem to receive a positive evaluation. In regard to the

fourth theme, his tendency to minimize and underestimate the seriousness of his experiences, Finn appears to be giving careful consideration to just how badly he had injured himself. Through engaging in this examination of how badly he had injured himself, Finn is also further developing the fifth theme of beginning to re-examine his experiences and ways of dealing with pain.

As mentioned, Finn was one of the participants who most clearly illustrated an unanticipated effect of this interview. He drew on the interview to help him develop a greater understanding of his experiences of pain. Finn's efforts were especially evident because of the dramatic shift in tone. Following a short period when the atmosphere of the interview became very uncomfortable, Finn's approach to the interview changed. He became much more contemplative and seemed to take a much more critical and questioning stance toward the experiences he chose to talk about. I think this change in tone and in attitude toward the interview contributed to Finn's next comments. Thinking about this experience, he said,

It was painful. But, I think of it more as embarrassing. I think it was probably more of an embarrassment at the time. (Drawing some more). More embarrassment. I thought of physical pain, but, how I think of the memory, more embarrassment than pain comes back to me.

Finn's comments also highlight the change in emphasis in experiences of pain which seemed to occur at this point in the interview, the drawing of the second Map, for many participants, both male and female. When asked to draw the second Map, many participants had difficulty thinking of an

experience of pain which had occurred in the specified age range, from age twelve through seventeen. For example, Cathy, whose interview is included in this chapter, said that she was having a very hard time thinking of an experience of pain which occurred when she was ages twelve through seventeen, although she had no difficulty thinking of an experience of pain which occurred at the ages of six through eleven, the age range asked about for the first Map. In the end, Cathy selected an experience which occurred when she was about eleven, saying it was the best she could do. Significantly, once Cathy had recounted the story about her experience at age eleven, she remarked that, now, she could think of several experiences which occurred when she was ages twelve through seventeen, almost as though, in telling the story about her experience at age eleven, she had removed a barrier to her memories of experiences of pain during this age range. Paris was one of three participant who refused to draw this second Map. He stated that he would not draw this second map because by this age he was used to everyday experiences of physical pain and knew that they were “no big deal”. He explained that, by the age of twelve, pain had become “more emotional”. Indeed, Finn has introduced an emotional theme, being embarrassed.

In the Life Story section of the overall interview, when he was asked how he thought he deals with pain, Finn appeared to draw upon the insights he had gained through the course of the interview. He drew upon the sixth theme, of re-examining and becoming aware of how he deals with experiences of pain when he said,

How I deal with pain? Yeah. I think I have the New England stoic- tendency to be stoic and minimize. Maybe it's in my family, the tendency to try to take responsibility for your own situation.... And, I don't blame others for things that happen and, maybe, for pain I have. Unless someone's gross negligence, or someone attacks you, then it's clearly someone's fault. But, it's my decision, my responsibility. [Finn's emphasis].

In making these comments, Finn seems to have arrived at a new synthesis of his views of the ways in which he deals with pain. He has not totally shifted his views on pain and ways of dealing with it, but, like many participants, he has taken the opportunity offered by the interview to examine how he deals with pain. Through doing so, he has developed some insights into the ways in which he handles pain and some of the life experiences which may have contributed to dealing with pain in these ways. He has drawn upon these insights to summarize his ways of dealing with pain and, to some extent, to re-examine and re-position his views.

Finn's re-examination of his ways of dealing with pain, and of his life experiences regarding pain, is also apparent in the comments he made toward the end of the Life Story section of the interview. Finn reflected on his surprising discovery that he had not been able to keep his experiences of physical pain separate from his experiences of emotional pain, but had, inadvertently, mentioned an experience which would generally be considered as emotional pain while talking about his second Map. He had also mentioned an experience involving more emotional pain during the Life Story Interview, commenting as did several male participants, on the pain of breaking up with a girlfriend. Talking

about whether pain can affect his personal life, during the Life Story Interview, Finn contemplated his surprising discovery that physical and emotional pain might not be so easily separated, saying,

Yeah. It can affect-even in terms of the communication which with you meet the world-accidents revisited. I assumed you meant physical pain at the beginning. I intended to stick with it [physical pain]. If I feel depressed, I'm not engaged with the world much. I got to talking about the emotional pain. I don't know how. But, that particular question made me want to differentiate between the two. Not qualifying it. I just thought "pain" referred to my physical pain. By then, we were almost finished. No, I didn't realize that---I remember, when I brought it up----my ex-girlfriend---the emotional realm. I was embarrassed.

Finn commented further on his new realization regarding his ways of dealing with his experiences of pain, developing the sixth theme of re-examining his experiences of pain. Asked about which areas of life his life he thought were affected by pain, Finn offered an interesting contrast between accepting that physical and emotional pain might not be so easy to separate and maintaining their separation, saying,

My skin. Although I wouldn't have thought that before the interview. I have to say, if I think of pain, I don't think of physical pain. It doesn't concern me that much. Not concerned. Emotional, psychological pain affects everything from my general sense of self confidence to eating patterns, sleeping patterns.

In making these remarks, Finn seems to be touching on a theme raised very clearly by several of the male research participants, who talked about a sort of syndrome or structured group of associations, consisting of "body aches", "body

pain, muscular and joint pain”, “pain resulting from a lack of exercise”, and “frustration” and “anxiety”.

This overall theme in the interview with men was clearly illustrated in the fourth theme in Jack’s interview, when he discussed the importance of physical activity and its complex relationships to identity and self image. While this theme is much less obvious in Finn’s interview, he seems to suggest it when he comments that “If I feel depressed, I’m not engaged with the world much.”, immediately after talking about physical pain. He also seems to be talking about something similar to this theme raised in many of the interviews with male participants, when he says, “Emotional, psychological pain affects everything from my general sense of self confidence to eating patterns, sleeping patterns.”

Finally, similar to most of the men interviewed for this study, Finn described himself as being not at all likely to talk to other people about pain. This arose as an important theme in the overall content analysis of the interviews with male participants. Finn described his reluctance to talk with others about experiences of pain, saying,

Mmm. No. I’m not in pain very often. Maybe, if I feel sick or have the flu. No. Even then. Really. Three to four years ago, my roommate and I both had really [Finn’s emphasis] bad flu. We couldn’t leave our rooms. Our eyeballs hurt. We got up and met in the communal living room for less than an hour, tried soup and the way we talked about it was to joke.

In conclusion, two aspects of the tone of the interview were striking features of this interview with Finn. First was Finn’s casual, offhand manner of describing experiences of pain. As an interviewer, I was struck by the

discrepancy between the content of Finn's descriptions, which made the injuries sound fairly serious, and the easygoing, unconcerned tone in which he recounted them. Second, there was an abrupt and striking shift in the tone of this interview, which occurred shortly after Finn recounted an experience in which he contracted a serious case of strep throat while visiting his grandparents on an island off the coast of Canada where there were no doctors available. I experienced a sense of extreme tiredness and Finn seemed to become, very briefly, somewhat hostile. As the interview progressed, the tone of the interview returned to one of cordiality and it appeared that this brief change in tone was related to Finn's discomfort in coming to a realization regarding this situation, which he wrote about in his second Narrative.

The shift in tone divided Finn's interview into two sections. In the first section of the interview, Finn appeared to be friendly and cooperative, if somewhat uninvolved. This was related to the first theme which arose in the interview with Finn, a theme of adapting a sensible, rational, logical approach to the content of the interview, discussing experiences of pain in everyday life. During this section of the interview, Finn brought up a second major theme of feeling that it was necessary for him to be responsible and manage events in his life, including painful events which occurred in the course of daily life. Finn expressed this with the phrase, "Just deal with it." Just prior to the shift in tone, two other themes arose, a third theme of questioning whether he and others in his life might be able to take better care of him and a fourth theme of tending to minimize and underestimate the seriousness of experiences of pain. Throughout

the interview, Finn also offered reflections on the relation between pain and memory, which emerged as a fifth theme.

After the shift in tone, a new theme appeared, one of beginning to re-examine his experiences of pain and his ways of dealing with pain in his life. Finn was one of several participants who stated that he had come to some new realizations regarding the ways in which he dealt with experiences of pain, saying that he found these realizations surprising. While Finn did not completely alter his ways of thinking about and dealing with experiences of pain, he clearly became more aware of how he dealt with experiences of pain and appeared to be reconsidering some aspects of the ways in which he handles pain. He seemed to give serious thought to whether he might not be able to take better care of himself and ask others to help care for him. Finn was one of the participants who said he was determined to limit his comments to experiences of physical pain. He expressed surprise at not being able to keep physical and emotional pain completely separate and at, inadvertently, bringing up experiences of emotional pain. Similar to several other male participants, Finn suggested that dealing with physical pain was easier for him. He briefly brought up issues of depression and lack of connection to the world which were related to the syndrome which was described by other male participants.

What information is provided by this method and analysis to answer the research questions?

This method and analysis provide information which addresses all three research questions.

Research Question 1: In what ways are men's and women's "constructions" of pain similar and different? and Research Question 3: What do men and women do to deal with pain? Sub-question: How are men's and women's constructions of pain related to what men and women do to deal with pain?

Differences

First, for both women and men, talking to others about experiences of pain seems to help in dealing with these experiences, although men are less comfortable and less likely to talk with others about pain. The two participants who appeared to be most comfortable dealing with pain as adults were both women, Cathy and Bianca. Both these participants emphasized, in their interviews, that, as adults, they talk to others about experiences of pain. In addition, they both said that their parents and family members not only "fixed it" when they experienced pain as children, but also talked with them about their experiences of pain. Both Cathy and Bianca described themselves as being able to deal with pain and move on with their lives. Bianca said, explicitly, that being able to talk with others about her experiences "makes me feel that I am not alone, not nuts, not crazy." Talking with others helps her understand what to anticipate, as Bianca, said "The sort of helpful, involved communication I am used to with my family and friends helps me to know what to expect."

Even if material help is always provided, both female and male participants reported that if adults, in childhood, did not talk with them about their experiences of pain, they found it difficult to deal with painful experiences. For example, a third female participant, Jan, appeared to be the least comfortable in dealing with experiences of pain. She portrayed her experiences of pain, in particular back pain, as disrupting her life, leaving her feeling out of control and giving her a feeling of foreboding. The magnitude of Jan's difficulties in dealing with pain is exemplified by her statement that she was particularly struck by reading on-line that "pain should not be a reason for suicide." Unlike Cathy and Bianca, Jan said that her parents would always take care of her when she experienced pain as a child, but did not talk with her about these experiences.

Although two of the three female participants whose interviews were examined in depth said that caregivers talked with them about their experiences of pain while they were growing up, neither of the two male participants said caretakers talked with them when they experienced pain in childhood. However, Jack, one of the male participants, said that, as an adult, he is finding people with whom he can talk about experiences of pain, which, he reported, helps him to deal with these experiences. The second male participant, Finn, said that he does not talk with others about experiences of pain. As adults, all three of the female participants said that they talk with others about their experiences of pain. As an adult, Jan has also found a few people with whom she can talk about experiences of pain, which she finds helpful in dealing with pain. It appears that being able to talk with others about experiences of pain helps people, both

women and men, in making sense of their experiences of pain, helping them to realize that they are not the only ones who have this experience and to anticipate what will happen.

This intensive examination of these five interviews provided an opportunity to examine five participants' constructions when asked to draw the second Map, an important point in the interview for most participants. Finn provided an excellent example of the connections male participants described making between physical and emotional pain during the age range asked about for the second Map. He was one of the three male participants who tried to keep his experiences of physical and emotional pain separate. In his second Map, he portrayed an experience in which he fell while skateboarding down a "really, really steep hill." Although his initial attribution was that this was an experience of physical pain, he spontaneously commented, "It was painful. But, I think of it more as embarrassing...but, how I think of the memory, more embarrassment than pain comes back to me."

At some point in their interviews, all three female participants portrayed experiences centering around pain in which they appeared to realize that males tend to be valued more than females. Two of the women, Cathy and Jan, described experiences of pain which occurred when they were about eleven years old, during which they seemed to realize that issues of gender and power affected their lives. For both women, the importance of gender issues in the stories they told did not seem to be entirely apparent to them. Both women said that these were important experiences, but they did not know why. Jan

described an experience in which she injured her knee by running into a stage, which she said was “different emotionally” and which she attributed to being “one of the few times when I went against authority-and I hurt my knee.” When her father arrived to take her to the doctor, Jan described her experience with the doctor and her father as “not like when I was little. I was the most awful experience.” and that her father stayed and “told his story”, which seemed to contribute to the troubling nature of this experience. Subsequently, Jan described herself as being a “goody-goody” whose physical activities were much more circumscribed.

Cathy recounted the dilemma she faced when she injured herself at school. She said that she felt that she shouldn't go to the school nurse or go home from school early, because she needed to show that she “can take it”, in order to maintain her status and power as the elder of two siblings. However, her boyfriend told her it would be alright to go to the nurse. Cathy finally did go to the nurse, but did not go home early. This story is similar to Jan's story of injuring her knee by running into a stage. Both Jan and Cathy seem to be talking about experiences in the age range asked about in the second Map in which they found themselves faced with quandaries concerning loss of status and power, and, for Jan, freedom, connected to assuming gender appropriate attitudes and behaviors. Bianca portrayed an experience in her first Map in which the birth of a brother who shared her highly valued bedroom was important.

Both male participants appeared to try to adopt a logical, cognitive stance toward the interview when they learned that it was about pain. Jack explained

that he deliberately formulated a plan or strategy to handle the interview. He said he tried to establish a central structure and to come up with answers before the interview began. Finn adopted a rational, logical stance toward the interview, making comments such as, “this seemed like a salient example of pain.” Male participants’ trying to take a rational, cognitive stance toward the interview seemed to be related to the difficulties male participants experienced in connecting physical pain to emotional pain and in dealing with their emotions regarding pain.

Finally, this chapter provided the opportunity to explore the syndrome described by male participants in more depth. Jack offered a particularly rich description of this syndrome in which a complex relationship between physical and emotional pain appears to be connected to the importance of physical exercise and sports, which he described as “intense, macho and very competitive and aggressive” to men’s senses of self and of self worth. Jack portrayed a dense pattern of relationships between physical activity, identity and self image, saying, for example, “I like sport. I need psychologically to know I can do it.”, “Physically and emotionally, it stays with me because I can feel the difference.” and “Psychologically, I am aware before I move of an overall sensation.” When he does this he “can feel” his image of himself as good and successful.

Similarities

Both female and male participants often reported that they had vivid or strong memories of the experiences of pain which they depicted. They also frequently said that these experiences were important in their lives, although they

often said they were not sure why these experiences seemed so important. For example, Finn described both his memory of his experience in Canada, where his severe illness was left untreated, and his experience falling while skateboarding down a very steep hill as a very clear and vivid memories, although he was not sure of their significance in his life until he began discussing these events. Cathy said that she remembered the experience she depicted in her first Map, although she could remember few individual experiences of pain from this period of her life, because a little dog licked her face, which made her cry. However, as the interview progressed, it became apparent that not crying when experiences of pain occurred was important to her image of herself as stronger than her younger brother because she was the older sibling, an image connected to issues of power, status, age and gender.

Both female and male participants appeared to use the interview as an opportunity to explore their experiences of pain which occurred during the course of everyday life.

Research Question 2: In what types of spaces and places of men and women have experiences of pain? Sub-question: With what people, if any, do they interact in these spaces and places?

This closer, more in-depth look at five participants' overall interviews suggested some themes which will be explored in more depth in the specific analysis of the Map Drawing Protocol. Cathy, Bianca and Jan portrayed environments somewhat closer to home than did Jack and Finn. Bianca, in particular, talked about an experience which took place in her bedroom for her

first Map and in her home for her second Map. In their Maps, neither male participant portrayed an experience which took place in his home, although Finn wrote about the experience of putting out the flaming curtains, which took place in his bedroom. These two male participants were somewhat more inclined to talk about experiences which took place farther from home. In addition, the male participants talked about more experiences which occurred outdoors than the female participants.

Chapter Six

THE NARRATIVES, THE MAPS AND THE SCALE

INTRODUCTION TO THE CHAPTER

This chapter deals with results obtained through analyzing the Narratives, the Maps and the standardized CSQ. While some results obtained from participants' Narratives and Maps have been dealt with to some extent in the previous results chapters, this chapter presents the results of the more detailed, planned analyses of both the Narratives and the Maps. These analyses provide data which allows some themes which emerged in the previous chapters to be explored further, especially the role of place in participants' experiences of pain. This chapter also briefly addresses the ways in which each of these three methods proved to be useful in the context of the overall interview.

THE NARRATIVES

First, the use of the two Narrative constructions at the opening of the interview played a key role in the overall interview, helping participants to focus and collect their thoughts

One important finding was that asking participants to write the two Narratives near the beginning of the interview appeared to serve an important function in the overall interview. Participants reported that being asked to write about two experiences of pain helped them collect their thoughts, think, reflect and focus on the issue of pain. Some participants remarked that they found

writing especially helpful since pain is not a subject about which we talk much in our culture. Several participants spontaneously commented on how useful they found writing about experiences of pain to have been. For example, after writing both her Narratives, Anya said, "It's interesting to see how the two experiences of pain are different. Before doing this, I never thought about the kinds of pain in my life". Bianca remarked, "Writing about things gave me a chance to put feelings into words...I'm curious about what I wrote. How different types of pain, emotional and physical, affect me." Sergei said that writing his Narratives made him, "reconstruct my thought process."

Participants' reports that writing the Narratives helped them to collect and organize their thoughts and explore their experiences of pain were especially interesting because this addressed a major concern which arose in the design of the overall interview. Based on narrative theory, it seemed to be a good idea to give participants this opportunity to put together their own ideas on their experiences of pain before asking them questions which might affect the way in which they constructed their experiences. Since narratives have been described by Jerome Bruner as a fundamental mode of human thought which provides a way of "ordering experience, of constructing reality" (Bruner, 1986, p.11) and that helps humans to deal with "intention and action and the vicissitudes and consequences that mark their course" (Bruner, 1986, p.13), it seemed reasonable to ask participants to write about their experiences of pain early in the interview. However, it was not clear whether it would interfere with participants' engagement in the interview if they were asked to be silent and write so early in

the interview, shortly after having the research project explained and just after meeting me, the interviewer. Theory on narrative suggested that participants should find the opportunity to pause and deliberately engage in a conscious act of narrative construction useful at the beginning of the interview protocol, which appeared to be the case in this study.

Second, compared to the planned, detailed analyses of the Narratives, participants' own comments on their two written Narratives provided a richer source of data.

After writing both Narratives, participants were asked to discuss each Narrative, in turn. In case participants did not spontaneously comment on several key issues, probes were designed to address these points. The information participants provided while discussing their two Narratives and, if necessary, responding to probes, furnished a rich source of data on how participants were constructing their experiences of pain. While detailed analyses which involved counting numbers of words, analyzing types of words and examining the ways in which participants structured their accounts, had been planned and were conducted, participants' own, spontaneous comments on each of their two written Narratives provided a more useful source of data for the purposes of this study.

Three types of word counts were planned: a count of total number of words used by women and men in their Narratives, a count of the types of adjectives used by women and men, and a count of positive emotion words,

negative emotion words and causal/insight words (see Appendix C for a sample analysis form). Although these counts were conducted, the information provided by these word counts was neither as clear nor as useful as expected. This was especially true of the count of the types of adjectives used by women and men. It appeared that, because of the overall research approach used, word counts were less revealing than expected because both female and male participants wrote about their experiences of pain, as requested in the directions. Research asking participants about their pain may limit the aspects of pain which participants feel they are being asked about. Support for this possibility was offered by participants' spontaneous comments on the standardized scale they were asked to complete at the end of the study. Several participants commented that they did not like filling out the scale. In particular, three participants found ways to adjust the scale's requirements to more nearly fit their own experiences, which will be examined in more detail in the discussion of the scaled responses at the end of this chapter.

The count of the total number of words was expected to reveal that women, who reported in the open-ended sections of the interview that they are more comfortable talking about pain than did men, used more words than men in their two written Narratives. This was the case, regardless of how length was assessed. The shortest Narrative written by a male participant contained 40 words, while the shortest written by a female participant consisted of 74 words. The shortest average (mean) number of words for both Narratives was 69 for a male participant and 76 for a female participant. The longest Narrative written by

a female participant consisted of 264 words, while the longest written by a male participant was 247 words, with a longest mean number of words for both Narratives of 255 for female participants and 218 for male participants. Finally, the mean of the number of words in the Narratives written by all female participants was 168.22 words while the mean number of words of those written by all male participants was 153.63 words. However, this difference in mean length was not large, 14.59 words, and could be accounted for in other ways, including the overall tendency of women to be more comfortable with verbal tasks than men.

The count of types of adjectives was expected to yield information on whether male participants were more likely to describe the pain itself while female participants were more likely to discuss the feelings associated with the painful experience, a frequent finding in research on pain using standardized scales. However, as mentioned, asking participants, both male and female, to write narratives on their experiences of pain seems to have shifted the focus to the experiential level for both men and women. The adjectives used by both men and women varied widely and included adjectives describing a number of dimensions in the experience of pain, including the degree of the pain, the type of pain, and the emotional and cognitive responses to the pain.

For example, in her first written Narrative, Zum, a female participant, described her experience of chest pain with the adjective “burning” and phrases “like tons of weight pushing my chest” and “increased weight”. She also described the physical appearance of her chest, using the adjective “red”, and

her overall experience of “difficulty breathing”. In his second Narrative, Finn, a male participant, described the amount of pain, writing “so much”, and portrayed both the activities involved in his care and the fever he was writing about with the same adjective, writing “bad [move on the part of his caretakers not to consult a doctor sooner]” and “bad [fever]”. In his second Narrative, Sergei, another male participant, used adjectives to describe his pain, including the phrases “a rather painful sensation” and “some sort of vascular problem” and the word “innocuous”. He also used adjectives to describe his overall experience, writing “sudden”, “annoying” and “almost scary”. Georgina, a female participant, also described the degree of her pain, using the adjective “worst” and her overall experience, using the adjective “frustrated”. Finally, Anya, also a female participant, used the adjective “cranky” to describe both her own state and the state of her back pain, which she wrote about as though it were a separate, independent entity, saying it “has moods” and “behaves.”

The word level count did not yield the expected information, highlighting more similarities in the complexity of women’s and men’s constructions of pain rather than the expected differences. However, although this analysis did not uncover great differences between women and men, it did reveal a greater tendency for male participants to use the adjective “annoying” at some point in their descriptions of their experiences while female participants were somewhat more likely to use the adjectives “sad”, “angry” and “guilty” to describe their experiences. The adjective “frustrating” was frequently used in the Narratives of participants of both genders. Again, because of the complexity of the use of

these adjectives, a simple count was not useful in portraying participants' use of these adjectives in their two written Narratives.

Finally, both men and women frequently used causal and insight words in their two written Narratives. Again, this may be because both men and women were asked to write about their experiences of pain. Once again, the difference was not discernible when single words were examined. However, when phrases and sentences were scrutinized it revealed that women were somewhat more likely than men to write about insights and causes on the level of "lessons learned about life" while men were more likely to write about what they had learned on the more specific level of how to deal with pain, often the particular experience of pain being discussed. Men also were more likely to write about insights in terms of the cause of the particular experience. However, this difference did not hold in all cases.

For instance, Kawika wrote in his second Narrative, "The pain was caused by the ITB.(which, he explained, is a part of the body)" , which expressed his conception of cause and his insight into this particular experience of pain. In his first Narrative, Luke wrote, "I just thought that, although I do take Advil when I have a headache, I never take medication for muscular/joint pain.", expressing insight into his ways of dealing with particular types of pain he experiences. Sergei wrote in his second Narrative, "The best thing is to try not to pay attention to it. If I keep thinking about it, I keep feeling it for a while. If I try to divert my attention to something else, the next thing I know, the pain is gone.", a more general reflection on ways to deal with pain.

On the other hand, female participants were more likely to talk about how pain had provided them with insights into how to deal with life in general. For example, Anya wrote in her second Narrative, “It made me learn important things about myself and life in general, so that in a way, I have benefited from it.” Bianca wrote in her first Narrative, “It taught me that I have to learn to accept the fact that I tried to be close to her, but not to feel bad about the fact that the effort wasn’t returned.” However, both women and men talked about having learned to be grateful for health, well-being and being free from pain. In her second Narrative, Bianca wrote, “I will no longer take for granted my ability to walk, run or move about without pain.”, an insight which is quite similar to that expressed by some male participants. For instance, Kawika, wrote in his second Narrative, “ I was glad when the pain went away...a new found appreciation for well- being.”

Third, more detailed analyses of the structure of the Narratives yielded a surprising finding. All the Narratives were clearly structured.

When the Narratives were analyzed looking for both Leventhal et al.’s (1987,1985, 1984, 1980) five components, 1) Label, 2) Cause, 3) Duration, 4) Course, and 5) Curability and the five critical ingredients for forming an acceptable narrative in our culture identified by Gergen and Gergen (1988), 1) Valued endpoint, 2) Related events, 3) Temporal ordering, 4) Causal linkages and 5) Demarcation signs, both the Narratives of all the participants contained all these components (see Appendix C for a sample analysis form). This was an especially surprising finding because pain is not discussed very much in our

culture, a point which research participants themselves frequently mentioned. Farmer and Good (1991), in their research on illness representations of AIDS in Haiti, found that people's representations of AIDS became more detailed, more elaborated and began to resemble each other more after AIDS had been part of the scene for a longer time. They reported that people appeared to have talked with each other about this new illness and shared knowledge, resulting in increasingly well-developed representations, which also shared more common features. Based on their research, one would expect to find that participants' representations of their experiences of pain would not be well elaborated, because participants noted that pain is not a topic of general discussion in our culture, and that women's representations would be more developed, since female participants reported talking about their experiences of pain more with others. Nevertheless, both female and male participants' two written Narratives displayed all the components identified by Leventhal and his colleagues and by the Gergens.

This surprising finding might be explained by the information obtained in the overall content analysis and the analysis of interviews with individual participants . Both these analyses revealed that pain forms a key component in people's lives. As will also be seen in the detailed analyses of the Maps, participants portrayed themselves acquiring information about their experiences of pain in a wide range of different settings. Because of this, it seems likely that participants continually picked up both verbal and behavioral cues in many important settings in their lives, which they used in forming well-structured

constructions of their experiences of pain, even though they were not aware of engaging in many formal conversations on the topic of pain.

THE MAPS-ON PLACE AND PAIN

First, asking participants to draw the two Maps constituted an important part of the overall interview. Being asked to contextualize their experiences of pain at two different points in their lives seemed to help participants construct these experiences and furnished a valuable source of data.

Like writing the Narratives, being asked to draw the two Maps constituted an important component of the interview. However, the Maps played a different role from that of the Narratives. While writing the Narratives afforded participants an opportunity to think, reflect and focus on experiences of pain, the Map Drawing helped participants recall, in a great deal of detail, experiences which had occurred many years previously. As Anya said, "It was fun to draw. It made me wonder. An interesting study." In addition, it was interesting to observe that most participants continued to draw as they discussed the experiences which they were depicting, often adding elements that seemed to further jog their memories. The process of drawing themselves and others in the settings in which these experiences occurred appeared to provide a powerful mnemonic aid.

Place has been identified as an aid to memory. People frequently comment on the powerful memories aroused by revisiting a place in which events in their life occurred. Many readers will recall the literature on the mnemonic

technique called the Method of Loci, in which people are advised to situate a number of items which they need to remember in places in a mental landscape, often along an imaginary street. When asked to recall these items, the person is advised to take a “walk” down this mental street, identifying the items as she or he encounters them in their locations on this mental route. Pain also seems to play a powerful role in memory. The combination of these two elements may account for participants’ abilities to reconstruct in great detail events which occurred when they were much younger.

Second, participants frequently described the places in which pain occurred in their first Maps, in which they were asked to depict an experience of pain which occurred when they were ages six through eleven, as places they especially liked.

Where do the women and men who participated in this study describe pain as occurring (see Table 3)? While it might seem likely that people would associate experiences of pain with places which they dislike, the participants in this study were more likely to say that the places they drew in their first Maps, in which they were asked to think of an experience of pain which occurred when they were ages six through eleven, were places which they especially liked, frequently places where they especially liked to play. They did not report that they liked these places because they experienced pain there. On the contrary, participants reported that because these were places where they liked to be, they spent a great deal of time in these places. As a result, they had memories of

many experiences of all types which occurred in these places. Their frequent use of these places made it more likely that painful experiences would be among their many experiences in these locations.

For example, when Cathy was asked whether the large family compound she depicted in her second Drawing was a place where she was likely to experience pain, Cathy replied that she was likely to experience pain there because so much of her activity as a child occurred in this place. However, she immediately added that she does not associate this place with pain. She said that she is still very fond of this place and has many happy memories.

Kawika, when asked what the place he depicted in his first drawing was like, replied,

It was a bike path through the forest. It was like a grassland located between the major forest and the suburbs. It was a nice place. I liked to go there and ride my bike sometimes. There were sheep and it was nice to watch them. Also, it was suburban, but almost rural. It took ten minutes to get there by train. This was where my maternal grandmother's home was and we went to spend the summer every other year. It was like a rural area, outside the city.

Kawika's description of the place where he had a bicycle accident while riding with his mother was similar to many participants' in that it conveyed a feeling of affection for a favorite childhood place.

Both Bertha and Finn depicted parking lots near their family homes in their first Drawings. Bertha said that the parking lot next to the apartment where her family lived was a favorite place to play because the parking lot was a little lower than the yard of her family's home. This created a slight drop and it was fun to

jump from one level to the other. However, because this parking lot was paved, it was easy to fall and hit herself on the pavement or the curb. Similarly, Finn said that he loved to play in the parking lot near his family's home. However, he also said it was easy to injure himself there. In the scene he depicted, he was playing in the wheel well of a large truck when he cut his hand badly, resulting in a "bloody mitten."

However, there were some participants who said they did not like the places where they had painful experiences. For example, Jack chose to depict a place where he had been molested by a family friend. As he drew, he described this room, saying, "It was foreign, dark, isolated and depressing". Jack also described the area where he grew up in negative terms, saying, " It was isolating, removed. It was an effort to go anywhere. It was isolating and concrete The front was all landfill. It was sandy and hard to grow things..." Julie described the closet in her bedroom where she and her teddy bear held their " hate club" meetings, saying that she did like it there, but " Yeah, in a like sick way. I felt sick back then, not just in retrospect. Something was not right about this. I didn't tell other people. This place was so like a frozen crypt." For these participants, the preponderance of events which they described occurring in the places they drew were painful. This seemed to color their overall feelings about these places. Nevertheless, in this study, perhaps surprisingly, it was unusual for participants to describe places where pain occurred when they were ages six through eleven in negative terms. Most frequently, participants said that their experiences of pain at this age occurred in places where they spent a lot of time because they

liked being there. Most participants reported that they also had many pleasant experiences in these places.

Third, participants' comments revealed that the physical environments in which they played as children, depicted in the first Map, played an important role in the way in which pain was dealt with by adults in the child's life.

Several participants' descriptions of their first Maps provided information regarding how the nature of the environment in which they were raised and played as children affected the ways in which adults dealt with their painful experiences. For example, in her first Drawing, Olivia depicted a house with a small yard. She drew a small, steel fence which completely enclosed this yard, proceeding to explain that this yard was paved, in its entirety, in concrete. As she drew, she described playing in this yard, which adjoined her caretaker's house in Queens. Olivia explained that she had always been told she was "clumsy". She said that this was because, at this age, she frequently fell and was always cutting and bruising herself, especially her knees. However, this paved concrete yard certainly must have played a role in these frequent injuries, although these injuries, in Olivia's description seem to have been attributed solely to Olivia's own clumsiness. Even at the time of the interview, when Olivia was an adult of twenty-seven, she described herself as clumsy. Olivia also explained that her caretaker had been chosen in large part because she had a house with a yard in which Olivia could play.

The parking lots which both Bertha and Finn portrayed in their first Map Drawings were favorite places to play. Both these participants mentioned that, as children, they lived in fairly affluent suburban neighborhoods on the East Coast of the United States, but that they chose these parking lots near their families' homes as favorite play areas. Not surprisingly, both Bertha and Finn also said that they frequently were injured in these places. Bertha's description of her mother's discomfort in dealing with her childhood injuries constituted an important element of her description of this experience. Although, based on Bertha's account, it appeared that her mother was a person who, in general, had difficulty dealing with Bertha's pain, it also appeared that Bertha's selection of play areas exacerbated her mother's difficulties in dealing with her child's pain. In addition, Bertha explained that, because she was playing in a dangerous place where she was not supposed to play, she experienced even greater hesitation in going to her mother for help. Finn described his mother's reaction when he appeared at home with what he referred to as a "bloody mitten". Although, based on Finn's description, it seems that his mother was fairly comfortable in dealing with her two son's injuries, it cannot have helped this single mother to know that her son played in a dangerous parking lot.

On the other hand, Cathy and Sergei spontaneously offered descriptions of childhood environments which seemed to facilitate their caretakers' abilities to care for them. Both described environments in which caretakers were able to stay nearby while conducting their daily activities and were easily able to "keep an eye" on them. Cathy described a family compound in Hong Kong, explaining

that many adult members of the family were always present and available to help her and her brother, should they hurt themselves. As a result, she and her brother experienced a great deal of freedom. As Cathy put it, they could “go anywhere”. Within these enclosed grounds, they felt that they could play as and where they liked. If they did injure themselves, some of the many adult family members present in the compound would be sure to notice and offer assistance. During her interview, Cathy explained that this environment played an important role in her feeling of comfort that “everything would be alright” if she hurt herself, and that adults would be there to “take care of it”. She described this situation as contributing to her own overall comfort in dealing with experiences of pain.

Sergei also depicted a childhood play environment in which he explained that his mother was able to easily keep an eye on him while he played. He said that he thought the nature of this environment facilitated his mother’s watching out for him and made her feel more comfortable. Sergei explained that, if he did injure himself, she would quickly become aware of it and be able to help, which he perceived as contributing to her confidence. Sergei, who grew up in St. Petersburg, USSR, depicted the block of flats in which he and his mother lived, explaining his drawing by saying that the apartments were built around a central courtyard. He said that this was a common arrangement in St. Petersburg, although he could not think of any exact replica of this arrangement which he had seen in the U. S. He explained further that he and his mother also lived on the ground floor. As a result, his mother not only had a good view of him while he played in this central courtyard, but she also could reach him quickly in case he

was injured. Sergei said that, even though his mother raised him by herself, this environment made her feel more comfortable about being available if he needed help.

In the experience he depicted, Sergei explained that he was injured while playing a game with sticks which was popular in St. Petersburg when he was a boy. While he and several other boys his age were playing this game in the courtyard of the apartment building where he and his mother lived, he was hit in the mouth by another boy's stick. He said that he was bleeding a great deal from his mouth when he ran home for help. However, Sergei explained that, after cleaning the wound and ascertaining that he was not badly hurt, his mother was relaxed enough about his injury to allow him to go out and resume playing this game with sticks. He said he thought this was partly due to the environment. She knew she would be able to watch him from her window in case he was injured again or needed further help.

Fourth, participants were less likely to describe the places in which pain occurred in their second Maps, in which they were asked to depict an experience of pain which occurred when they were ages twelve through seventeen, as places they especially liked.

The places participants depicted in their second Maps, in which they were asked to depict an experience of pain which occurred when they were ages twelve through seventeen, were less frequently described as places participants especially liked. In part this was because some of these settings were places

where the participants did not go by choice. These were more likely to be places where they were required to go. In addition, these were more likely to be institutional settings. For example, six participants depicted school environments. None of these participants expressed fondness for the school settings themselves. Both female and male participants described such experiences as anxiety over ability to perform, experiences in which they needed to be disciplined or confrontations with peers. For example, Sergei portrayed the boys' room in his school where another boy beat him up for saying negative things about the boy's girlfriend. Both Kawika and Sooty depicted themselves feeling anxious about being able to perform adequately in new schools to which they had transferred. Alasdaire depicted a scene which took place in a corridor of his school in which he was being led back to his Spanish class after being suspended for cutting this class numerous times.

Both women and men also talked about experiences which occurred in their neighborhoods while drawing their second Maps. Perhaps because participants were able to go to a wider range of neighborhood places in this age range, they tended not to mention a specific location in the neighborhood. For example, Bertha portrayed an experience in which, "I injured myself racing a bus on my bike." Georgina described being trapped under an overturned kayak in a body of water near her home. Bob depicted himself getting drunk "anyplace. Wherever I was". However, Finn portrayed a steep hill near where he lived where he injured himself skateboarding, adding that this place where he often went.

Participants also depicted scenes in or near their homes in their second Maps. These were more likely to be settings which participants said they liked. For example, Anya portrayed herself being beaten by her mother for staying out late, an experience which occurred in their home, which was a place which she liked.

Fifth, the second Map constituted an important point in the interview for almost all participants, both women and men. The age range, ages twelve through seventeen, asked about for the second Map seemed to be an age at which issues of identity and gender became involved in experiences of pain.

The drawing of the second Map constituted an important point in the interview. This was an unexpected finding. However, at this point in the interview, when participants were asked to think of an experience of pain which occurred when they were ages twelve through seventeen and draw the setting in which it occurred, participants experienced noticeable difficulties and discomfort

First, several participants said that they felt they needed to take a break at this point in the interview. This was the case both for participants who had recently taken a break and for participants who expressed no other desire for breaks at any other point in the interview. For example, Cathy paused at this point in the interview, saying that she needed to take a break. She went to the ladies' room, reporting when she returned that she was still not able to think of an experience of pain which occurred in this age range.

Second, many participants paused for a long time at this point in the interview, going on to say that they were having a very difficult time thinking of an experience of pain which occurred when they were ages twelve through seventeen. Although, when asked to draw the first Map, some participants had also paused for a bit while trying to think of an experience of pain which occurred in this age range, they usually quickly went on to select an experience. In addition, many participants said that they paused because so many experiences came to mind that it took them some time to decide which one to depict. However, when asked to draw the second Map, participants usually hesitated for a longer period of time. They not only expressed but displayed more signs of discomfort with the task. In addition, two participants, Jan and Paris, even refused to draw this second Map, although both continued with the rest of the interview and appeared to remain engaged in the interview process.

The difficulties participants expressed in remembering an experience of pain which occurred when they were ages twelve through seventeen were especially surprising since none of the participants had difficulty recalling a painful experience which occurred when they were ages six through eleven, the age range asked about for the first Map. It seems counter-intuitive that participants would have more difficulty thinking of an experience of pain which occurred in the later age range called for in the second Map, since they were being asked to think of an experience which had occurred more recently.

Even after these long pauses, many participants said that they still were not able to think of an experience of pain which occurred when they were in the

requested age range. For instance, Kawika said, “ It’s hard to think of things in that age range.” Cathy finally said that she was not able to think of an experience of pain which occurred in the specified age range, that the best she could do was to portray an experience of pain which occurred when she was still eleven but almost twelve. She explained that she could think of this experience of pain, which occurred when she was almost twelve, but no experiences of pain after that.

Comments made by Sergei, Luke, Cathy and Jan may help to explain these unexpected difficulties with selecting an experience of pain which occurred when participants were ages twelve through seventeen. Sergei said, “More moral pain. I was joking, but it does count. So far, I’ve concentrated on physical pain.” He went on to comment, “

That age group. Not pain. I thought more of mental pain. You start to deal more with real life.....Real life. In childhood an accident seems like a big deal. It’s the first time. But, you get used to it.

Luke’s comments were similar. Luke said, “I’m trying to get out of emotional stuff. I can’t remember anything other than emotional stuff from that age range.”

For several participants, the age range asked about for the second Map seemed to be a time during which issues involving emotions, social expectations, identity and gender became involved in experiences of pain. As Luke’s comments suggest, for many male participants this seemed to be an age range within which issues of physical pain and emotional pain became more difficult to separate. As mentioned, male participants often appeared to have difficulty

dealing with emotional aspects of pain. It was when they were asked to make their second Drawings that the three male participants who tried to limit their descriptions of pain to physical pain, Kawika, Finn and Bob, found that they were including experiences of what they themselves described as more mental or emotional pain.

For female participants, this age range appeared to be a time when social expectations regarding gender-appropriate behaviors and attitudes created situations involving conflict and loss of status. For example, in the experience which occurred at age eleven which Cathy finally selected, she portrayed herself dealing with conflicting messages regarding her stance that she could “take it” and not cry, even though she was a girl. Notably, after portraying this experience, suddenly, to her surprise, Cathy found that she could recall many experiences of pain which occurred when she was ages twelve through seventeen. Jan’s portrayal of an experience in which described herself as being disobedient, which she connected to injuring herself, seems similar to Cathy’s. Although Jan drew this experience for her first Map, she said she was about Cathy’s age, eleven almost twelve, when it occurred. Jan explained that she regarded this experience “only in time as the precedent for my pain experience”. After this, she described herself saying, “I was no longer a risk taker.” and “I had become a goody-goody who only sat on the bench, not participating.” Although she immediately followed these comments by saying that this was normal, Jan refused to draw the second Map.

Sixth, important differences between women and men appeared in both the first and second Maps

Overall, in both Drawings, female participants were more likely to portray environments in or close to their homes while male participants were more likely to portray environments which were farther from their homes (see Table 3). In both Drawings, women were more likely to talk about and depict indoor, home settings. In both Drawings, female participants frequently depicted themselves in their bedrooms, explaining how important their bedrooms were to them as places where the space belonged to them, where they could be alone, which offered refuge and where they felt safe and secure. None of the male participants depicted himself in his own bedroom in either Map. One male participant depicted a scene in a bedroom, Luke, who portrayed a scene in his mother's bedroom in which his mother was in bed. One male participant, Finn, mentioned a scene which occurred in his bedroom in his first Narrative. However, in his Narrative, Finn described a social event, in which several friends were visiting him and his bedroom appeared to function more as an entertainment area than as a private area.

Women also frequently said they went to bed when they experienced pain, while no male participants reported going to bed when they experienced pain. For example, Cathy said that when the pain from her menstrual period is especially bad, she goes to bed, rests, and reads light material. Zum said that she often goes to bed when she experiences pain. She thinks, sometimes cries, sometimes tries to forget about the pain, and, sometimes, sleeps.

On the other hand, in both Drawings, male participants were more likely to talk about and depict themselves in outdoor settings. In addition, men were more likely to report that they associated pain with being indoors and feeling good with being outdoors. For example, Luke said he found, “ The indoors, painful. But, outdoors, I feel really good.” Male participants portrayed themselves in athletic settings such as gyms and athletic fields more frequently than did female participants. In their second Maps, female participants somewhat more frequently portrayed environments farther from their homes. However, in their second Maps, male participants depicted environments farther from their homes more frequently than did female participants.

In their first Maps, women were more likely to portray environments which were in or near their homes, such as bedrooms, yards, or neighborhood environments not too far from their own homes. In their first Maps, ten of the eleven female participants (91%) portrayed one of these three types of settings fairly near their homes. Four of the eleven female participants (36%) depicted bedroom settings. One female participant depicted herself in bed, while the other three depicted themselves in their bedrooms, including Julie, who drew herself in the “hate club” in her bedroom closet. Four of the eleven female participants (36%) depicted family yards or similar settings, such as a family compound or the yard of a caretaker. Finally, two of the eleven female participants (18%) depicted neighborhood settings more distant than the yards of their homes, including Sooty’s depiction of her mother’s being attacked by a robber in their London neighborhood and Georgina’s portrayal of a neighbor’s dog biting her neck. Only

one female participant, Jan, depicted a scene which took place at some distance from her home, an experience which took place during a school trip.

In their first Maps, men were more likely to portray settings farther from their homes. Only two male participants (18%) depicted settings in their homes, Luke's depiction of his mother's bedroom and Alasdair's portrayal of a scene in the family home. In addition, two male participants (18%) portrayed environments near their homes. Sergei depicted a scene which took place in the courtyard of the apartment building where he lived with his mother. Finn depicted a scene which took place in the parking lot near his home. Four male participants (50%) depicted environments more removed from their homes, including two athletic fields, Kawika's depiction of a forest trail near his grandmother's home and Jack's portrayal of the house of family friends. In addition, four (50%) of the environments depicted by male participants in their first Maps were related to athletic activities, including two athletic fields, the courtyard space being used for the game with sticks and the forest path on which Kawika and his mother were riding bikes.

In their second Maps, women continued to be more likely than men to portray environments in or near their homes. Four of the eleven female participants (36%) depicted scenes in their bedrooms in their second Maps. Three women (27%) depicted scenes which took place in their neighborhoods. Two women (18%) portrayed scenes which took place in school settings. One female participant refused to draw a second Map.

In their drawings for their second Maps, male participants tended to portray scenes which took place farther from their homes than the scenes they depicted in their first Maps. Two male participants (18%) depicted scenes which took place in the neighborhoods near their homes. Four men (50%) portrayed scenes which took place in school settings. One male participant refused to draw a second Map.

THE SCALE

The standardized Coping Strategies Questionnaire (CSQ) (see Appendix B) offered yet another view of the way women and men constructed their experiences of pain. The CSQ consists of forty-eight statements about activities people engage in when they feel pain, all of which begin with the phrase, "When I feel pain". The research participant is asked to indicate how much she or he engages in each activity on a scale of zero to six. There are two additional questions, which also ask for a rating on a scale of zero to six, that ask the participant to rate the degree of control she feels she has over pain on an average day and how much she feels she is able to decrease pain. The CSQ provides seven categories of strategies for dealing with experiences of pain, including: Diverting Attention, Reinterpreting Pain Sensations, Coping Self Statements, Ignoring Sensations, Praying/Hoping, Catastrophizing and Increasing Behavioral Activities. Each statement is scored in one category. However, the scale also includes six "filler items" which are not scored, so do not enter into the analysis and are not included in one of the categories.

First, there were gender differences in the categories in which women and men endorsed the most statements on the CSQ.

Women more often endorsed statements scored in the category of Coping Self Statements than men (see Table 4). Eight of the eleven female participants (73%) in this study most frequently endorsed statements scored in this category. None of the women in this study endorsed statements in the categories of Reinterpreting Pain Sensations or Diverting Attention most often.

The statements most often endorsed by male participants were distributed over a wider range of categories, although male participants also endorsed statements in the category of Coping Self Statements most often (see Table 4). Five of the eight male participants (64%) endorsed the most statements in the category of Coping Self Statements. However, one of these five male participants was Sergei, who endorsed the most statements in this category when considering emotional experiences of pain, which will be explained later in this section of the chapter. Three male participants endorsed the most statements in the category of Ignoring Sensations. None of the male participants endorsed the most statements in the categories of Praying/Hoping or Diverting Attention. Only one male participant endorsed the most statements in the category of Catastrophizing, although this was Bob, who endorsed the most statements in this category when considering emotional pain, which will be explained later in this chapter.

Second, participants' spontaneous descriptions of the ways in which they usually dealt with pain and the statements they endorsed on the CSQ did resemble each other in many cases.

For many participants, the ways in which they spontaneously described dealing with experiences of pain did resemble the categories they selected most frequently on the CSQ (see Tables 4 and 5). Ten of the nineteen participants (53%) gave the highest ratings to the statements in the category on the CSQ which most nearly corresponded to the ways in which they spontaneously described themselves dealing with pain. For example, consider Jan, whose story was also examined in detail in the previous chapter. She offered a description of the ways in which she deals with pain which is very similar to the statements on the CSQ which are grouped in the category of Catastrophizing, which is the category in which she endorsed the most statements on the CSQ. Jan described herself saying "I am very sensitive to pain" and "I always have to be ready for it [pain]..."

On the CSQ, the categories into which participants' selections are grouped can be used to form a profile of the ways in which participants deal with pain. This allows more than one dimension of coping to be used in describing each participant's ways of dealing with pain. When these profiles are used, the relationship between ratings on statements which participants chose to endorse and their own descriptions of the ways in which they deal with pain bear an even greater resemblance to each other. Georgina provides a good example of such a situation. She scored highest in the category of Coping Self Statements, with a

score of 20. However, she scored almost as high in the category of Ignoring Sensations, with a score of 18. Both these scores taken together closely resemble the ways Georgina portrayed herself dealing with pain in her own, spontaneous descriptions, although her own descriptions might lead one to expect that the scores in these two categories might be reversed, with Georgina scoring higher on Ignoring Sensations and slightly lower on Coping Self Statements. As shown in table 5, Georgina described herself saying, “ I don’t like to think about pain. I joke about my own experience, but not others’. I distract myself . I think about or do something else.”, similar to statements in the CSQ category of Ignoring Sensations. Georgina then added, “Pain, I ignore it and go on.”, a statement similar to those in the Coping Self Statements category.

Third, the CSQ appeared to over emphasize the category of Coping Self Statements.

The CSQ seemed to over emphasize participants’ endorsements of statements in the category of Coping Self Statements. In some instances I thought this overemphasis occurred because the scale did not allow for other aspects of participants’ endorsements of this category to be considered (see Table 5). The example just provided, of Georgina, who said ‘ Pain, I ignore it and go on.” provides an example. Although this statement most closely resembles those included in the Coping Self Statements category, it includes mentions of “ Ignoring”, which also suggests the CSQ category of Ignoring Sensations.

Some participants seemed to be talking about a way of dealing with pain which involved endorsing statements in the category of Coping Self Statements, but which included other dimensions which were not tapped by the CSQ. For example, Cathy described herself saying, "I can face it-not cry in front of people." but added, " I always see people will take care of me...I talk to people who tell me how to handle it and I get information." The latter part of her comment seems to constitute an important aspect of her ways of dealing with pain. However, there were no statements on the CSQ similar to this which she could have endorsed. The way in which Cathy describes talking to others is very different from either option involving other people offered by the statements on the CSQ, which include "I think of people I enjoy doing things with.", which is scored in the category of Diverting Attention and "I try to be around other people.." which is scored in the category of Increased Behavioral Activity. In fact, Cathy scored high on both these dimensions, which raises questions about how she interpreted these statements. Olivia offered another example. She described her way of dealing with pain, by saying, "Don't fuss. Keep going." which was similar to statements in the CSQ category of Coping Self Statements. However, she immediately followed this comment, which she made spontaneously, by continuing to say, "I feel I have to deny my emotions. If you don't, you're not strong, you're weak. Suck it up.", a statement which seemed to indicate discomfort with this way of dealing with experiences of pain.

Overall, the CSQ seemed to accord well with participants' own statements regarding the ways in which they deal with pain. It is impossible for a brief scale

to capture the same level of nuance as a longer interview format. However, it seems that the CSQ tends to overemphasize the category of Coping Self Statements. Participants seemed to be tapping into a more diverse range of experiences when they endorsed the statements in this category. This suggests that the CSQ could be examined and developed further.

Finally, based on the results of the overall interview, I was not sure what kinds of pain participants were thinking of when they were filling out the CSQ. Because of the complex relations between physical and emotional pain which participants in this study described, I wondered whether participants were thinking of physical or emotional pain. Both female and male participants often said they dealt with physical and emotional pain differently. Also male participants often said that they were uncomfortable talking about and dealing with emotional pain. I wondered whether female and male participants were interpreting the statements in the same way. Participants' spontaneous comments on the CSQ helped to examine this concern.

Fourth, participants spontaneously offered comments and information on how they were experiencing the CSQ which suggested dimensions which the CSQ might not be addressing.

Another surprising finding in this study was that participants spontaneously commented on the CSQ and how they were experiencing the statements on it. It is important to reiterate that participants were asked to complete the CSQ at the end of the interview. Because the CSQ was positioned

so late in the interview, it seems likely that participants became involved in the more open approach used in the preceding sections of the interview and that this influenced their views toward the CSQ. Several participants offered additional information on their attitudes toward being asked about their experiences of pain in this questionnaire format after discussing their experiences of pain at length, about how they were reading the questions, their problems in fitting their experience to the ways in which statements were made on the scale and their view of pain as including and, possibly, combining both physical and emotional pain.

Some participants, usually women, simply said they did not like filling out the scale. For example, Julie said, “ I don’t like this part of the interview. I don’t like doing this. This list really bothers me. I don’t know why it bothers me so much. It feels biomedical.”

Bertha said that she felt so strongly about some of the statements included in the CSQ that she wanted to comment on those items which disturbed her most. Her comments, which prompted me to take an extra copy of the CSQ and record the remarks she made on specific statements, provide some insight into issues which participants said they encountered in trying to answer questions on the CSQ. Concerning the CSQ statement, “I leave the house and do something such as going to the movies or shopping.”, Bertha commented that she thought “This statement assumes that you will be in your house when pain becomes an issue for you”, a comment which addresses the de-contextualized nature of the CSQ. Bertha also objected to the statement, “ I take my

medication.”, saying that, for her, “This statement seems to assume that one will only take medication which has been prescribed”. Finally, concerning the CSQ statement, “I have faith in doctors that someday there will be a cure for my pain”, Bertha said, “This only applies to chronic pain.” The statement concerning taking one’s medication, to which Bertha objected, is a filler item on the scale. However, the other two statements are not filler items.

Two male participants provided information on the way in which the CSQ deals with the complex and ambivalent relations between physical and emotional pain which were revealed by in this study. These two male participants, Sergei and Bob, offered to fill out the scale in two different ways (see Appendix G). Sergei explained that he thought dealing with physical pain and mental or emotional pain were different, and that he needed to record this difference in his responses to the CSQ. He decided to fill out some of the items with different labels, “ M” for “mental” and “P” for “physical.” He chose to do this for only six items. Overall, Sergei’s ratings when he said he was talking about his experience of physical pain gave him the highest score in the category of Reinterpreting Pain Sensations. This is not surprising since Sergei rated his answers for physical pain much higher than those for mental pain on four items, three of which were in the category Reinterpreting Pain Sensations. The fourth statement on which he rated physical pain higher than mental pain was in the category of Increasing Behavioral Activities. His ratings on what he termed more “mental or emotional” pain, gave him the highest score in the category of Coping Self Statements. This is interesting when one considers that women, who

reported being more comfortable with emotional experiences of pain, tended to endorse statements in the Coping Self Statements category more than men. However, his ratings for mental pain were higher on two items, both of which were in the category of Diverting Attention. Sergei's comments raise concerns regarding how representative of overall ways of dealing with pain scores on the CSQ are. It appears that men's tendency to separate physical and emotional pain affects the frequency with which they endorse statements in different categories of the CSQ.

Finally, Bob said that, having discovered a "new view" of pain, which included his experience of depression, he felt he needed to fill out the CSQ twice, once from "my old view of pain, of regular pain" and "once from my new view of pain", adding, " This didn't originally come to mind, but it was, actually, a huge part of pain in me." There were too many differences in his answers based on these two different views to record all of them here, so facsimiles of Bob's endorsements of statements on the CSQ from the perspectives of his two "views" have been included in the appendix (see Appendix F). Overall, using his "old view" Bob scored highest in the category of Coping Self Statements while using his "new view" he scored highest in the category of Catastrophizing.

Fifth, what about gender differences and the CSQ?

The ratings provided by female and male participants on statements in the category of Coping Self Statements provide one good example of difficulties with the scale which might be related to gender. At first glance, women appeared to

rate the category of Coping Self Statements higher than men. Eight of the eleven women (73%) endorsed statements in the category of Coping Self Statements with the highest ratings, while five of the eight men did so (62%). However, the average rating given statements in the category of Coping Self Statements by women was 22.8, while the average rating given by men was 21.8. These two averages do not exhibit a great difference. Moreover, when men's answers were computed using the more "physical " ratings made by Sergei and Bob, the average rating for men in the category of Coping Self Statements was 24, actually higher than women's ratings, while using their rating for more " emotional" forms of pain it was 21.3. A clear pattern of results does not emerge here. It seems that men are, overall, more likely to endorse statements in the category of Coping Self Statements when they are talking about more physical than emotional pain. This is consistent with the discomfort men expressed during the interview about dealing with more mental or emotional types of pain. However, Sergei's ratings on what he termed more "mental or emotional" pain, gave him the highest score in the category of Coping Self Statements, which is interesting when one considers that women, who reported being more comfortable with emotional experiences, more frequently endorsed items rated in the category of Coping Self Statements.

Since the CSQ does not provide for a differentiation between experiences of more physical and mental types of pain, it seems likely that the measurements for men on Coping Self Statements are either under- or over-estimated. Since these errors in measurement may go in either direction, it is not clear whether

mis-measurements of this sort might not go in both directions, canceling each other out to some extent. However, these results raise concerns about whether the CSQ contains items which reflect men's ways of constructing their experiences of pain, including the tendency to concentrate on physical pain and not to include interpersonal strategies such as talking with others among their ways of dealing with pain.

The substantial agreement between the ways in which participants spontaneously described the ways in which they deal with painful experiences and their rating of statements on the CSQ provides some support for the validity of both procedures. However, both participants' spontaneous descriptions and their comments on the CSQ suggest features of the CSQ which merit further examination, especially its decontextualized nature and the likelihood that it is based on male constructions of pain and, thus, is not sensitive to some of the ways women report dealing with pain.

What information is provided by these methods and analyses to answer the research questions?

This chapter provides information which answers all three research questions and which serves to add validity to the results reported in previous chapters. Research Question 1: In what ways are men's and women's " constructions" of pain similar and different?,

Research Question 2: In what types of spaces and places do men and women have experiences of pain? Sub-question: With what people, if any,

do they interact in these spaces and places? Research Question 3: What do men and women do to deal with pain? Sub-question: How are men's and women's constructions of pain related to what men and women do to deal with pain ?

The analysis of the Narratives revealed that women's Narratives were longer than men's which may be related to the finding that women regard talking about pain with others as an important way of dealing with pain. However, this could also be due to women's greater facility with verbal tasks. Women were more likely than men to write about lessons they learned about how to deal with life in general from painful experiences, while men were more likely to talk about what they learned about what caused specific experiences of pain. Both female and male participants said they learned not to take well-being and freedom from pain for granted. All the Narratives written by both women and men were clearly structured and complete based on two forms of analysis. This was a surprising finding since men said they did not talk about experiences of pain as much as women and all participants said they didn't think we talk about pain very much in the course of regular conversation in our culture. However, it appeared that participants had many opportunities to be involved in interactions in which experiences of pain were intersubjectively constructed through both practices and discourses during everyday life.

The analysis of the Maps revealed that most participants, both female and male, depicted the places where they had experiences of pain during the ages of six through eleven as places they liked, often favorite places to play. Participants

reported that, since they spent a lot of time in these places, they were likely to have many experiences of all kinds in them, including experiences of pain. However, some participants who reported experiencing a predominance of painful experiences in the environments they depicted in their first Maps described these environments in negative ways. It seemed that the preponderance of painful experiences had given a negative coloration to these environments for them.

The places participants chose to depict in their second Maps, where they were asked to portray an environment in they had an experience of pain when they were ages twelve through seventeen revealed two important points. First, both women and men said that these were not likely to be environments they especially liked. Participants said that these were often places they had to go to, not places where they chose to be. Second, these were more likely to be institutional settings, such as schools.

For both female and male participants, being asked to draw the second Map constituted an important point in the overall interview. Participants paused at this point in the interview and often had difficulty thinking of an experience of pain which occurred in this age range. Moreover, participants often evidenced some discomfort at this point in the interview. Participants' drawings and comments revealed that the age range asked about for the second Map was a time during which issues involving emotions, social expectations, identity and gender became involved in experiences of pain. For female participants, this age range appeared to be a time when social expectations regarding gender-

appropriate behaviors and attitudes created situations involving conflict, loss of status and freedom. For male participants this seemed to be an age range within which issues of physical pain and emotional pain became more difficult to separate. Male participants often said they had difficulty dealing with the emotional aspects of pain. It was when they were asked to make their second Drawings that the three male participants who tried to limit their descriptions of pain to physical pain, Kawika, Finn and Bob, found that they were including experiences of what they themselves described as more mental or emotional pain.

In both Drawings, female participants were more likely to portray themselves in settings close to or in the home. Female participants frequently depicted themselves in their bedrooms and even in their beds. Women explained how important their bedrooms were to them as places where the space belonged to them where they could be alone and which offered safety, security and refuge. Women often said they went to bed when they were in pain, where they thought, rested, slept, tried to forget, and read light material. None of the men depicted themselves in bed when they experienced pain.

In both Maps, male participants were more likely to portray environments which were farther from their homes. Men were also more likely than women to portray outdoor environments, including sports settings. This difference increased with the second Map. While women slightly less frequently portrayed places in or near their homes, men much more frequently depicted environments away from their homes in their second Maps.

Finally, the analysis of the CSQ, the standardized scale used to assess ways of dealing with pain, showed that women and men deal with pain differently. The categories in which participants endorsed the most statements on the CSQ seemed, for the most part, to be consonant with the ways of dealing with pain which participants reported in their spontaneous accounts during the interview. This provides evidence to support the validity of both the interview and the CSQ. Women were more likely to endorse statements scored in the category of Coping Self Statements than men. The reason for this is not clear, although it appeared possible that this might be related to women's greater comfort with the emotional aspects of experiences of pain. It appeared possible that, because women are more likely to connect physical and emotional pain, women and men may not be reading the statements provided on the CSQ in the same ways, leading women to endorse more statements in the category of Coping Self Statements. In addition, some dimensions of women's experiences of pain did not seem to be adequately represented in the statements provided, including the interpersonal strategy of talking with others and women's willingness to deal with emotional aspects of pain.

Participants' spontaneous descriptions during the interview and their comments on the CSQ suggest features of the CSQ which merit further examination. Chief among these are its decontextualized nature and the likelihood that it is more oriented to male than female ways of constructing experiences of pain, such as emphasizing physical pain and not liking to talk with

others. As a result, the CSQ may not provide opportunities for women to report ways of dealing with pain that are important to them.

TABLE 4
COPING STYLES QUESTIONNAIRE
FEMALE PARTICIPANTS

Participant	Diverting Attention	Reinterpreting Pain Sensations	Coping Self Statements	Ignoring Sensations	Praying/Hoping	Catastrophizing	Increasing Behavioral Activity
1-Bertha	14	4	17+	7	3	13	17+
5-Jan	16+	9	14	7	13	29*	14
7-Zum	18^	0	22*	9	7	11	11
8-Olivia	15	4	25*	9	22*	21*	17+
9-Sooty	13	12	33*	15	20*	12	14
10-Georgina	4	6	20*	18^	2	3	12
11-Anyia	16+	11	26*	9	3	6	16+
12-Cathy	22*	9	36*	29*	36*	3	27*
13-Archis	0	0	26*	6	8	0	3
14-Bianca	11	2	20*	24*	4	9	19*
17-Julie	0	13	12	0	22*	3	8

CSQ Ratings
Hi=36
Med=18
Lo=0

*=Above Mean
+=Within 1-2 Points of mean
^=Mean

High score(s) for each participant is (are) in bold

TABLE 4
COPING STYLES QUESTIONNAIRE
MALE PARTICIPANTS

Participant	Diverting Attention	Reinterpreting Pain Sensations	Coping Self Statements	Ignoring Sensations	Praying/Hoping	Catastrophizing	Increasing Behavioral Activity
2-Luke	17+	11	22*	22*	7	0	19*
3-Kawika	10	14	26*	27*	10	8	20*
4-Paris	15	6	34*	11	17+	2	23*
6-Sergei- "Physical"	9	20*	19*	12	0	4	16+
Sergei- "Emotional"	15	0	19*	12	0	4	16*
15-Jack	10	17+	17*	19*	7	15	16+
16-Finn	17+	9	30*	14	8	4	17*
18-Alasdaire	14	4	16+	9	11	18*	21*
19-Bob-"Old View"	22*	19*	28*	19*	15	8	18*
Bob-"New View"	6	15	7	1	2	31*	7

CSQ Ratings

Hi=36
Mid=18
Lo=0

*=Above Mean
+=Within 1-2 Points of mean
^=Mean

High score(s) for each participant is (are) in bold

TABLE 5 PARTICIPANTS' CSQ SCORES COMPARED TO WAYS OF DEALING WITH PAIN WHICH THEY DESCRIBED SPONTANEOUSLY-Part One-Women

Participant	Highest Category Endorsed on CSQ	Representative Spontaneous Description of Ways of Dealing with Pain/Category on CSQ That Spontaneous Description Most Resembles
1-Bertha	Coping Self Statements/Increasing Behavioral Activity	I was scared to go back home [after cutting her face when she was six or seven]. I was not supposed to be doing this. I was afraid I'd get in trouble. The problem was I did some damage to myself. I was concerned about Mom. Mom tried to control herself." Coping Self Statements
5-Jan	Catastrophizing	" I am very sensitive to pain." , " I was just promoted and I felt like I'd never walk again." , " I am not happy to be like this. This not a pleasant life experience. I have to be ready for it [pain], not rolling with the punches but forced to be very vigilant." Catastrophizing
7-Zum	Coping Self Statements	"I don't want to burden people. I'm sensitive. I want to DEAL with pain rather than forget about it. I try NOT to take medications, they can be addictive....Pain is a fact of life. You have to deal. I might go to the doctor or take medication if it persists. Coping Self Statements/Ignoring Sensations
8-Olivia	Coping Self Statements	"Don't fuss. Keep going. I feel I have to deny my emotions. If you don't you're not strong. You're weak. Suck it up." Coping Self Statements
9-Sooty	Coping Self Statements	"Stick it out. Along the way you can complain. But, at the end of the day, stick it out. Don't give up. Don't let pain control your life. Take control as much as you can." , " I f you're concerned with yourself in pain, you'll feel pain. If you shrug it off, you won't feel pain." Coping Self Statements
10-Georgina	Coping Self Statements	" I don't like to think about pain. I joke about my own experience, but not others'. I distract myself. I think about or do something else. Pain. I ignore it and go on." Ignoring Sensations
11-Anya	Coping Self Statements	" I try to manage pain, benefit from it. Emotional pain is scary, back pain [physical] is not scary. It seems lie I have more control over it. Emotional pain is not like physical pain, which is frustrating. You can use it-healthy." Coping Self Statements
12-Cathy	Coping Self Statements	" I can face it-not cry in front of people. I always see people will take care of me, the doctor MAYBE....I talk to people who tell me how to handle it and get information." Coping Self Statements
13-Archis	Coping Self Statements	" In my family, people often just said to 'forget about it'. I often just wait for a couple of days." Coping Self Statements/Ignoring Sensations
14-Bianca	Ignoring Sensations	" Talk about it. Try to learn something from it.....Learn from your experience. It strengthens you and helps you grow. For physical pain, I go to the doctor. But, with my foot, I didn't WANT this problem. I didn't want to admit I had a problem that could prevent me from doing the things I want. It came and went for a while and I hoped it would go away." Coping Self Statements /Ignoring Sensations
17-Julie	Praying/Hoping	I think I have a high threshold for pain because of dance. Also, herpes can be VERY painful. And, now I don't-emotional pain has to be talked about now. You can't let it fester. It's different. Don't tolerate it. Try to DO something about it, change your perspective. Don't just express it, get feedback. Coping Self Statements

PARTICIPANTS' CSQ SCORES COMPARED TO WAYS OF DEALING WITH PAIN WHICH THEY DESCRIBED SPONTANEOUSLY-Part Two Men

2-Luke	Coping Self Statements/Ignoring Sensations	"See, I remember my contacts with my early family. When a child falls, they try to distract the child, saying something like 'Look at the clown'. My mother did this, She tried to put herself in a different frame of mind. She would try to distract herself." Ignoring Sensations
3-Kawika	Ignoring Sensations	" I hate it if people use it [pain] as an excuse for things. I saw an incident in a play group where a child was running. He fell flat-tough fall. I was impressed. He was 3-5 years old. The father wasn't unsympathetic and said, 'Can you handle it?' The child started to cry, but it didn't happen. I think because of the attitude of the father-kids fall. Mothers reward a child-better to cry. What are you supposed to do? There's a moment when you decide to cry or not." Coping Self Statements
4-Paris	Coping Self Statements	" I was born to evade trouble and pain. I can sniff it a mile off.", " Pain is going to happen. It's not as bad as it seems. Analyze it, don't blame yourself, but ask, 'What did I contribute? What did I do to inflict this?' Don't do it next time. Then let it go. You can't repair it. But you can prevent some pain." Coping Self Statements/Ignoring Sensations
6-Sergei "- physical and emotional"	Physical=Reinterpreting Pain Sensations/Emotional=Coping Self Statements	" I don't get a lot of pain.", "I pay attention and try to see what's going on." "About physical:" Once I had a pain in my back. It was more uncomfortable than painful for a couple of weeks. I went about my daily business, stooped over and slowed down.", " I try to tough it out." "The best thing is to try not to pay attention to it [pain]. If I keep thinking about it, I keep feeling it for a while. If I try to divert my attention to something else, the next thing I know the pain is gone." Coping Self Statement
15-Jack	Ignoring Sensations	" I am very good at subduing everyday pain. I find a way to dull pain through distraction, orally or through EATING.....I smoke pot, drink alcohol, it can be daily, usually in the evenings. I depend on this daily maintenance of pain." Ignoring Sensations
16-Finn	Coping Self Statements	"Yeah, I think I have the New England stoic-tendency to be stoic and minimize. Maybe it's in my family, the tendency to try to take responsibility for your own situation." Coping Self Statements
18-Alasdaire	Increasing Behavioral Activity	"I try to distract myself-any number of ways. Top are movies, books, drugs and alcohol, shopping, people-socializing. That's a big one. Like talking on the phone and e-mailing." "Put off pain, face it later. For now, relax." Increasing Behavioral Activity.
19-Bob-"new and old views"	Old=Coping Self Statements/New=Catastrophizing Statements	He actually said very little about how he deals with pain during the course of the interview: "We didn't take a lot of aspirin at home. Mom was a vitamin freak.", "In my family we suffer through it a lot without complaining. Everyone in the family, you know. We don't sweat the small stuff, I guess." Coping Self Statements

Chapter Seven

DISCUSSION

The goal of this chapter is to discuss how the research findings reported in the previous three chapters answer the Research Questions and relate to key theoretical issues. The chapter begins with a brief summary of the results of the study, discussing how the overall results of the study answer each Research Question. Next, I address what the results of this study can contribute to our understanding of several key theoretical issues. While most of this discussion draws on the theoretical material presented in the first chapter, some new material is introduced. This is because, in the first chapter, I included only the conceptual material on which I drew to construct this research. However, while considering the results of the study, the importance of other theoretical material to a thorough explanation of the results became evident. I was aware of some of this material while constructing the current study, but the material's relevance was not apparent to me until I saw the research results. Some of the material is new. I became aware of it, it was pointed out to me or it was published after the study was designed. Since this material did not play a role in my formulation of the study, it did not seem appropriate to present it in the first chapter.

The discussion of the theoretical material begins with a consideration of place and pain. The important role of place in participants' constructions of their experiences of pain is addressed, including a presentation of the complex relationship between place, identity, culture and society revealed by participants'

responses. Next, I discuss gender, since gender similarities and differences in the construction of experiences of pain was a fundamental issue in this study. Third, I address the surprising finding that pain seemed to play a key role in participants' construction of self. This section includes a discussion of the contribution this research makes to a biopsychosocio-cultural model of human health and illness and introduces the fourth section of the discussion, which deals with the roles of personal stories compared to master discourses in the construction of experiences of pain. Fifth, the methods used in the study are considered. This chapter concludes with a discussion of ethical issues raised in this research.

SUMMARY OF MAJOR RESEARCH FINDINGS

Research Question 1: In what ways are women's and men's constructions of pain similar and different?

There were many similarities in the ways female and male participants constructed their experiences of pain

First, interviews with both male and female participants revealed that participants were quite aware of the distinction made in the Western, biomedical model between physical and emotional pain. However, surprisingly, in view of the ubiquity of the expert biomedical discourse in the United States today, none of the research participants was able to adhere to this distinction throughout the interview. Even three male participants who tried to limit themselves to describing only experiences of physical pain, were not able to maintain a

bifurcation between experiences of physical and emotional pain. In addition, since they did not adhere to the biomedical distinction between physical and emotional, or mental, pain, both female and male participants discussed a wide range of experiences of pain. These included experiences of physical pain such as stomachaches, ear pain and hurting a finger while catching a football and experiences of emotional pain such as Olivia's "issues with my father" and the pain Alasdaire experienced from "working on music" and "not working on music."

The research also revealed that, for both female and male participants, their experiences of pain were constructed from interactions with a wide range of different people, including parents and caregivers, other relatives, friends, peers, and authority figures. Because participant's constructions of pain drew on their interactions with many different people in their lives, their constructions of pain were also tied to many areas of their lives. These included home and family, school and work experiences and experiences connected to the wider social and cultural milieus, such as Sooty's pain at being bi-cultural and unmarried at the age of twenty-eight and Sergei's painful experiences of discrimination as a Jewish person growing up in St. Petersburg, USSR. In addition, both female and male participants talked about experiences of "collective" and "shared" pain as well as personal, individual experiences of pain, pointing to the shared, social nature of the construction of pain. For both female and male participants, experiences of pain seemed to play a key role in their constructions of self and identity and in their perceptions of the world and how they are placed in the world.

Participants' comments in the interviews showed that, as adults, both female and male participants dealt with pain in a manner similar to the way in which their family members had dealt with pain when the participants were young. During their interviews, several participants commented on this connection themselves. For example, as Georgina, a female participant, talked about her experiences of pain, she said that she was beginning to think that "the way my mother dealt with me when I had painful experiences as a child has had a lasting effect on the way I deal with pain", while Finn, a male participant, said, "I think I have the New England stoic-tendency to be stoic and minimize. Maybe it's in my family..."

However, there also were many differences in the ways female and male participants constructed their experiences of pain.

First, while male participants emphasized that they did not like to talk with others about their experiences of pain, avoiding such discussions as much as possible, female participants said that they were not only comfortable talking with others about their experiences of pain, but that talking to others about their experiences of pain was very important to them. Female participants reported that they frequently discussed painful experiences with friends and relatives and described their family members and friends as helpful, supportive and understanding in helping them deal with these experiences. In addition, female participants emphasized that, through talking with friends and relatives, they obtained information about others' experiences and what treatments might be

helpful. None of the female participants said that she deliberately avoids discussing experiences of pain with others. On the other hand, male participants said that they were only likely to talk with other people about experiences of pain when it was absolutely necessary, usually if they were in extreme pain or because their abilities to perform adequately were affected. Some male participants also reported that, when they did talk about pain, they were likely to joke or tell “war stories.”

Male participants were also more likely to describe themselves as worrying about pain, even relatively innocuous experiences of pain such as muscle cramps. Female participants rarely discussed being worried about experiences of pain. Male participants’ worries about their experiences of pain often seemed to be associated with fear that they would not be able to perform adequately or that their ability to perform would be impaired. For example, Bob said that he counted and performed some simple arithmetic after running into a pole on a basketball court just to check that he could still think properly.

Although male participants did not describe themselves as being likely to talk with others about experiences of pain, the constructions of their experiences of pain which they presented in their two Narratives were well elaborated. It seems likely that men acquire a considerable amount of information about how to deal with pain through the frequent non-verbal exchanges with male peers and authority figures which they portrayed in their two Drawings. Men often depicted such exchanges occurring in outdoor spaces where other men were present.

Many of the male participants talked about a complex of issues which seemed to constitute a sort of “syndrome”, defined as “a group of signs and symptoms that occur together and characterize a particular condition or a set of emotions or actions which usually form an identifiable pattern” (Webster’s Ninth New Collegiate Dictionary, 1990, p. 1197). This syndrome consisted of body aches, body pain associated with muscular and joint pain, pain resulting from lack of exercise, frustration and anxiety. It appeared to be related to the perception, on the part of male participants, that body aches and muscular pains were a sign of their lack of exercise, their “lack of drive to go out there and do it”, as one male participant, Luke, phrased it. It appeared that, for many male participants, the perception that they were not taking part in physical activity was intimately tied to their perceptions of their own identities and to their feelings of self worth. This syndrome seemed to be connected to male participants’ need to feel that they were engaged in physical activities, especially sports, in order to maintain a positive concept of themselves. Male participants also reported dealing with pain by engaging in activity, especially sports. On the other hand, female participants were more likely to withdraw from physical activity and to isolate themselves when they experienced pain. Rather than engaging actively with the world, these women described themselves as preferring to be alone to try to deal with their pain. Several female participants reported that, when they experienced severe pain, they were likely to go to bed and try to deal with the pain by forgetting, reading, crying, thinking or sleeping.

None of the female participants talked about a similar “syndrome” or combination of signs and symptoms that occur together. However, some female participants spoke specifically about two types of pain, chest pain and back pain. Female participants who talked about chest pain dealt with it differently from male participants who discussed chest pain. Women were more likely to connect chest pain to stress. For example, Sooty said, “If I’m really stressed, I get chest pain.” Some male participants, particularly Jack, described chest pain in terms of a feeling of tension in his chest which was part of the syndrome discussed by some male participants. However, female participants did not connect chest pain to any overall pattern of related symptoms, emotions and actions. Some female participants also talked explicitly about back pain. None of the male participants chose to discuss experiences of back pain, although some male participants said that they had experienced back pain.

Of course, only female participants talked about pain related to their menstrual periods. There were three particularly striking features of female participants’ descriptions of menstrual pain. First, women frequently reported being told by medical practitioners that the only available treatment for menstrual pain is taking birth control pills. However, these women also reported that the birth control pills did not really help and that they often experienced side effects from taking them, such as bloating and weight gain, which made matters worse. Female participants reported that when they expressed dissatisfaction with taking birth control pills to deal with menstrual pain, medical practitioners often were not sympathetic. Second, some female participants reported being told that

menstrual pain is a “natural” part of being a woman and that they should just put up with it. Third, women tended to blame themselves for their experiences of menstrual pain, as well as for other experiences of pain. For example, Zum said, “ For the cramps, I blame myself. If I catch cold, don’t keep myself warm enough. There’s a reason for it. Myself...Maybe the pain lasts longer because I don’t take medication. I caused it. I deserve to suffer. Again, I did the same thing. I know better. Now I deserve to suffer.”

A few women portrayed themselves as having pain completely take over their whole being. None of the male participants portrayed themselves in this way. For example, Zum, both depicted and described herself solely as an “ear” when she was talking about her experience of ear pain. She said that the pain totally absorbed her consciousness, taking over her entire being. None of the male participants depicted themselves as wholly consumed by pain. Female participants also often described and depicted themselves solely in terms of body parts, such as an ear, lips, face or hands.

Women talked about pain as being helpful, although male participants did not. For example, Bianca stressed that pain can make her connect with people who are important to her in her life and, thus, helps to foster these connections. Another female participants, Anya, explained that she finds pain can be helpful in pushing her to learn and make choices.

Men were more likely than women to try to limit themselves to discussions of physical pain. Two male participants explicitly stated that they intended to limit their discussions to physical pain, while a third said he just assumed that physical

pain was what I meant by “pain”. Several male participants revealed that they had decided to make a deliberate effort to talk about physical pain because they felt more comfortable discussing physical than emotional, or mental, pain. In addition, some male participants explained that, when they heard that this was an interview regarding pain, they had adopted a deliberate strategy or plan for dealing with the interview. For example, Jack explained that he had decided to form a central organization for his interview. Female participants appeared to be more comfortable talking about emotional pain. Moreover, female participants often expressed interest in exploring the relations between experiences of physical and emotional pain. Female participants appeared to be much more comfortable with the idea that physical and emotional pain could not be kept separate and were much more likely to form connections between physical and emotional or mental pain. However, to complete the complex picture of relations between physical and emotional pain portrayed by the participants in this study, even female participants, who were more comfortable with connecting their experiences of physical pain to their experiences of emotional pain, frequently spoke about how different dealing with physical and emotional pain was. Female participants sometimes reported finding emotional pain more “scary”, although male participants seemed to find emotional pain much more frightening to deal with than did female participants.

Research Question 2: In what types of spaces and places do men and women have experiences of pain. Sub-question: With what people, if any, do they interact in these spaces and places?

There were similarities between female and male participants in the spaces and places in which they depicted experiencing pain.

First, most participants, both female and male, said that the places they depicted in their first Maps were places they especially liked. For both female and male participants, the places they depicted in their first Maps, in which participants were asked to portray an environment in which they had an experience of pain when they were ages six through eleven, were often favorite places to play or places in the home. Both female and male participants explained that, because they liked these places so much, they spent a great deal of time in them and, therefore, were likely to have many experiences, both painful and enjoyable, in these places.

In addition, both female and male participants revealed that the physical environments in which they played as children, depicted in their first Drawings, played an important role in the way in which pain was dealt with by the adults in the child's life. For example, Cathy explained that she usually played in a large family compound when she was in this age range. Because this space was enclosed, she and her younger brother were free to play as they liked. Nevertheless, since it was a family compound, many adult members of the family were always around to help if she or her brother were hurt. Sergei depicted an apartment complex with a central courtyard. He said that his mother was able to

keep an eye on him, which made her more comfortable in dealing with him if he was injured. However, participants who were born and raised in the U.S. often portrayed dangerous environments where they played as children, such as parking lots and paved yards. On the other hand, both female and male participants were more likely to explain that the places which they depicted in their second Maps, in which they were asked to portray a place in which they experienced pain when they were ages twelve through seventeen, was not a place they particularly liked.

For both women and men, drawing the second Map was an important point in the Interview. Many participants experienced discomfort at this point in the interview, including two participants, Paris and Jan, who refused to draw the second Map. Although both these participants remained very engaged in the interview and completed the remaining sections, both expressed discomfort with this part of the interview and, finally, said they preferred not to draw the second Map. Many participants paused for longer periods of time at this point in the interview than at any other point in the interview. They expressed discomfort and sometimes asked to take a break. In addition, at this point in the interview, both female and male participants often said that they were having difficulty thinking of an experience of pain which occurred during this age range. This was surprising because participants experienced little difficulty thinking of experiences of pain which occurred in the age range asked about for the first Map, which was earlier in their lives, and, thus, had occurred longer ago.

Based on the comments made by participants when they were asked to draw this second Map, it appears that participants experienced a change in the way they constructed their experiences of pain toward the beginning of this age range, particularly at the age of about twelve. Participants explained that when they were younger, physical pain seemed to be a more dominant issue. However, in this age range, participants explained that emotional or mental pain became more of an issue. Also, more connections seemed to be formed between physical pain and emotional pain. For example, the three men who tried to limit themselves to descriptions of physical pain all began to discuss more emotional aspects of pain at this point in the research interview. In addition, participants' experiences of pain seemed to become more tied to issues of identity, including gender, ethnicity and class, and to cultural and social issues during the age range of twelve through seventeen asked about for the second Map.

However, there were also differences in the types of spaces and places in which men and women portrayed themselves having experiences of pain and in the types of people with whom they depicted themselves interacting in these spaces and places?

Overall, in both Drawings, female participants were more likely to portray themselves in places in or close to their homes while male participants were more likely to depict themselves in environments farther from their homes. This difference increased from participants' first Maps to their second Maps. Women

were increasingly likely to portray settings close to or in their homes in their second Drawings, while men were increasingly likely to depict themselves in places farther from their homes in their second Drawings. In particular, women were much more likely than men to depict themselves their bedrooms or even in bed. Women explained how important their bedrooms were to them as places where they could be alone, where the space belonged to them, where they could find refuge, safety and security. None of the male participants portrayed themselves in their own bedrooms or in bed, although for his first Narrative, Finn wrote about a scene, which was more of a social scene, entertaining friends, in his bedroom. Female participants were also more likely to depict scenes in which they were interacting with others in interpersonal situations or were alone.

On the other hand, male participants talked about and portrayed themselves in outdoor settings, participating in outdoor activities including sports, more often than female participants. In addition, while describing these settings, men sometimes commented that they associated pain with being indoors and feeling good with being outdoors. Male participants often depicted scenes in which they were engaged in sports activities with male peers present. Men were also more likely to portray scenes in which they were in school settings. In addition, male participants were somewhat more likely to depict scenes in which authority figures, especially male authority figures outside the family and home, were berating them.

**Research Question 3: How do men and women deal with pain? Sub-
question: How are men's and women's constructions of pain related to
what men and women do to deal with pain?**

For both women and men, their constructions of their experiences of pain seemed to be closely tied to their senses of self, to their images of themselves as people. However, the sense of self for male participants seemed to be connected to ability to perform well and to display prowess in front of male peers, especially to being able to display competence in such physical activities as sports. Male participants linked inactivity and lack of drive to do things to a complex which included both physical pains, such as body and muscle aches, and more emotionally oriented experiences, such as anxiety, frustration and depression. They explained the importance to them of engaging in physical activities, especially sports, to deal with pain. In some cases, their engagement in physical activity in the face of bodily injuries appeared to jeopardize their physical health. Men described themselves as being unlikely to talk with friends, especially male friends, about pain, especially emotional pain, but as being likely to engage in activities, especially sports, with other males as a form of communication.

Male participants said that it is important to them to appear physically strong and competent. Male participants appeared to be uncomfortable engaging in discussions of situations in which they might appear to be weak or not in control, such as talking about pain. Alasdair expressed this idea clearly when he said, "In general, I don't think people are very interested in hearing

about your pain. Good news, accomplishments-but pain is not a frequent topic”.

Men also said that they were only likely to talk with others about experiences of pain when it was necessary to explain why their ability to perform adequately was affected. This unwillingness to talk about experiences of pain on the part of men also appeared to be connected to the tendency of male participants in this study to report that they worried about pain.

Male participants also expressed greater discomfort than did female participants about discussing and dealing with emotional pain. Men frequently reported having developed a strategy or cognitive plan to deal with the interview when they heard that it dealt with pain. They sometimes described employing a cognitive strategy, such as deciding to limit themselves to discussions of physical pain or forming a structure for the interview, to deal help them deal with an issue such as pain which might prove uncomfortable for them to discuss.

While male participants reported that they avoided discussing experiences of pain, female participants said that talking with others about experiences of pain was very important to them. They said that talking with others about experiences of pain was meaningful to them and helped them deal with pain. Female participants described themselves as obtaining support, encouragement and useful information through talking with friends and family members about their experiences of pain. Unlike male participants, female participants rarely talked about worrying about experiences of pain. However, some female participants did stress that they felt that painful experiences provided them with

opportunities for growth in their lives and for fostering connections with the people in their lives who are important to them.

Women seemed less likely than men to take action in order to deal with pain. For example, while female participants also talked about chest pain, relating it very generally to “stress”, they did not talk about taking any action to counteract this painful experience. Female participants seemed more likely to withdraw from physical activity and to isolate themselves when they experienced pain, rather than engaging actively with the world. They often portrayed themselves alone in their bedrooms, sometimes in bed, trying to deal with the pain by forgetting, reading, crying, thinking or sleeping. None of the male participants portrayed himself in bed or in his own bedroom at any age. Female participants sometimes described blaming themselves for their experiences of pain. Some female participants even said that they thought they deserved to suffer because some of their experiences of pain were their own fault.

Women were also more likely to portray themselves as having pain completely take over their whole being. For example, Zum depicted and described herself solely as an “ear” when she was talking about her experience of ear pain, saying that the pain had totally absorbed her consciousness. None of the male participants depicted themselves as wholly consumed by pain. Female participants were also more likely to portray themselves solely in terms of a body part, such as an ear, lips, face or hands.

Finally, female participants often seemed to experience conflicting feelings about themselves as women and how their ways of dealing with pain reflected on

who they are as people. For example, Cathy talked about her concerns with loss of status and power if she behaved in ways that were permitted for women but not men, such as crying when she experiences pain rather than showing that she “can take it”. Olivia was one of the women who expressed conflicting feelings about being able to express her emotions, saying that she was frequently admonished not to cry, even when she experienced pain, which made her feel that she had to deny her own feelings. Thus, although female participants were more comfortable than male participants in dealing with emotional pain and were more interested in connections between physical and emotional pain, their comfort with their emotions sometimes seemed to cause conflict and to threaten them with lowered status and power.

Finally, it is important to note that both women and men described experiences while growing up during which they learned about gender-appropriate behaviors regarding pain. In addition, both women and men seemed to pay prices for dealing with pain in ways consistent with these gender-related pressures.

PLACE AND PAIN

Place encompasses this entire discussion of pain. Because participants were asked to identify their ethnicities in their own words, their responses revealed the complicated, intricate interrelationships between place, identity, culture and ethnicity which these research participants experience in their daily lives. Many participants expressed discomfort in trying to fit their experiences of

who they are and where they come from into the standard categories for ethnicity usually provided in the United States. Participants who were not born and raised in the United States described serious difficulties in trying to make their own understandings of who they are conform to the standard categories for ethnicity with which they find themselves forced to deal in the United States. For example, Archis, a female participant from Barbados, said that she never selects the category of African-American, because, “ In NO WAY (the very strong emphasis is hers) am I American!” Even participants who were born and raised in the U. S. frequently communicated difficulties in trying to fit their experiences of themselves, who they are and where they come from, into standard categories for ethnicity. For example, Julie, another female participant born and raised in upstate New York, said, “Caucasion...French-Canadian and just a little Irish-and who knows?”

These difficulties in using standard categories for ethnicity reflect the complex relations between place, culture and society which participants in this study portrayed. Many participants devoted a great deal of time to describing their efforts to negotiate social and cultural experiences which span widely divergent places in the world. They explained how their experiences of culture and society involved working to bridge several different worlds, across both space and time. Some participants said they identified with places they had never been or where they had lived only briefly but were able to relate to the local mixture of cultural and ethnic backgrounds. The interviews with Sooty and Kawika offer particularly striking examples.

Sooty's descriptions of her own identifications with place and ethnicity expressed the complications of the way she finds herself situated in the world. Sooty described herself as a person who must live by bridging several social and cultural worlds which are widely dispersed geographically. Throughout her interview, Sooty emphasized how painful many aspects of this situation are for her. She explained that she was born in London, England, but is of East Indian descent. Currently, she is trying to live life as a New Yorker in a society she describes as more "individualistic" than what she describes as the "collectivist" culture from which she comes. In addition, she said she finds it very difficult to be so far from her close-knit East Indian family who live in London.

Sooty went beyond this to portray her difficulties in dealing with many of the social and cultural traditions to which she feels she must adhere. She explained that some of the most important practices which affect her life originated in places to which she has never been, places which she has never even visited. For example, she explained that she must adhere to East Indian traditions regarding arranged marriages. These customs have been handed down by older generations of her family based on their experience living in East India, a place she has never seen. She also described struggling to incorporate the mixture of English and East Indian cultures which she has experienced as a child and adolescent growing up in London, England. Currently, as a young adult coming from this complex spatial, social and cultural background, she explained further that she is trying to adjust to the "individualistically" oriented culture of contemporary life in New York City, USA, while adhering to many of the

customs transmitted to her from this mixture of cultures by her family. She revealed that she is in New York to attain the Ph.D. which forms part of her family's expectations of her and that she has not entirely ruled out an arranged marriage. She explained that, in the meantime, she often feels very unhappy knowing that her failure to marry at the age of twenty-eight is making her family suffer and is regarded by others as "almost abnormal". However, she said she is also struggling to avoid the arranged marriage to a man of similar ethnic background which her family expects because she doesn't think that such a marriage will make her happy.

Kawika also provided an eloquent portrayal of the complicated relations between place, culture, identity and ethnicity with which he struggles to deal. Like Sooty, Kawika described his difficulties in bridging multiple worlds. Of Japanese-German descent, with a Japanese father and a German mother, Kawika portrayed his difficulties in moving between Germany and Japan. One of the major difficulties he described was adjusting to the different school systems he experienced in these two cultures. For example, in his second Drawing, he portrayed what he described as his feelings of "alienation and fear of failure" at a new school in Japan. He said he found it hard to adjust to the different way of teaching and felt alienated because he was attending this school because he is biracial while most of the other students at this school were there because their families were involved in diplomatic work or worked with large corporations. He explained his view of his ethnicity and place identity by saying that he strongly identifies with the society and culture of contemporary Hawaii. Although he lived

in Hawaii for only a short time, this is a place where he found many other people with ethnic and cultural backgrounds similar to his own.

A surprising finding related to place was that, despite the diversity of settings in which these nineteen participants were born and raised, their gender-related constructions of pain were similar to each other for women and men, respectively, and consistent with mainstream research on gender identities conducted in England and the United States (Phoenix et al., 2003; Pollack, 1998). The “situatedness”, the emphasis on location, provided by the social constructivist view (Holland, 1997, Lock, 1999) and the geographical construct of structuration (Pred, 1983, 1984) upon which this study is based, provided information which offers insights into how and where the exchanges which influence gender-related ways of constructing and dealing with the body in pain took place in these participants’ lives. Regardless of the countries and cultures in which they were born and raised, males talked about and portrayed outdoor activities and settings farther from home more often than females. In addition, not only were a larger proportion of the settings men depicted outside the home, but the distance of the settings from male participants’ homes increased for their second Map, in which they were asked to depict experiences of pain which occurred when they were older, ages twelve through seventeen. On the other hand, female participants not only portrayed more experiences which took place in the home, but also portrayed a greater proportion of experiences which occurred “deep” within the home, such as in bedrooms and in beds. As female

participants grew older, in their second Maps, they did not depict experiences which took place farther from home as frequently as male participants did.

Since this research is based on the view that the construction of self and identity is a “situated accomplishment” in which self and identity are actively created and maintained, by individuals who are agents, through everyday practices and discourses which occur in real places, information on the kinds of interactions female and male participants engaged in and where they took place is vitally important. As Haraway (1991) argues, the alternative to the naturalized and essentialized body is a perspective on embodiment that emphasizes location. She points out that this emphasis on location allows one to comprehend experience from the standpoint of a particular body placed in particular ways in the larger social and cultural world. Haraway also points out that such an embodied standpoint makes it apparent that embodied humans occupy non-equivalent positions from which they experience only some types of interactions. Any given individual only has access to partial information, which permits that individual to grasp only limited aspects of any situation. Schepers-Hughes (1992) advises us to pay attention to the body as both individually and collectively experienced and constructed in accordance with the social constructivist position that humans do not encounter a world in which categories and meanings are already determined, but that the categories and meanings humans need to grasp “reality” are co-constructed through the practices and discourses of their everyday activities in social groups (Holland, 1997) which occur in real places. From this perspective, humans engage in an ongoing

process through which they co-construct the system of meanings for the social group. Coming from different perspectives, they struggle and negotiate, through multi-vocal activities and conversations, to construct the systems of knowledge and meaning which will be dominant in their worlds. Those engaged in these negotiations exercise varying amounts of power and influence, which affect their abilities to negotiate meaning relevant to their own lives.

Male participants depicted themselves participating in outdoor activities, including sports, more often than female participants. They described interactions with other males, often peers, although older males and authority figures were also depicted. The “syndrome” consisting of body aches, muscular and joint pains, frustration, anxiety and depression, which was discussed by several male participants, upon closer analysis, appeared to be connected to concerns about being able to engage physically with the external world, especially by participating in physical activities like sports, which one man, Jack, described as “intense, macho and very competitive and aggressive”. It appears that the construction of the male body which men in this study described in terms of this syndrome, takes place in these outdoor sports settings, which seem to be important in these men’s lives regardless of where they were born and raised. Activity seems to play an important role in this construction. Men described themselves as being unlikely to talk with friends, especially male friends, about pain, especially emotional pain, but as being likely to engage in activities, especially sports, with male peers. Male participants often portrayed older males as authority figures who conveyed messages regarding the importance of being

able to perform adequately. Some male participants also depicted older women, such as mothers, who were more likely than the women's mothers to demand that they be stoic and restrain emotional expression.

Female participants were more likely than males to portray themselves in settings in or near the home and to describe interpersonal encounters. Unlike the men, female participants were more likely to say that they withdraw from physical activity and isolate themselves when they experienced pain. Rather than engaging actively with the world, these women often described themselves as preferring to be alone to try to deal with their pain. Several female participants reported that, when they experienced severe pain, they were likely to go to bed and try to deal with the pain by forgetting, reading, crying, thinking or sleeping. This was closely related to the finding that female participants were more likely to portray themselves in bed or in their bedrooms, while none of the male participants portrayed themselves in bed or in their own bedrooms. Since women in this study reported that their bedrooms are especially important to them as places where the space is theirs and where they can be alone and find refuge, safety and security, it appears that women withdraw into these deeply interior places in the home to deal with pain in contrast to men who feel they must engage with the outside world to deal with pain.

Women emphasized how important the interpersonal activity of talking to others is to them in dealing with their experiences of pain. Talking with others, often female friends and relatives, appeared to help women construct a sense of self in which pain was less threatening because they received both support and

information about others' experiences and possible treatments. This is in accord with narrative theory, which says that humans need to be able to draw on past experience in order to understand current experience and know what to anticipate in the future. Women did not say that they had adopted cognitive strategies to deal with the interview, as many men did, and were more comfortable talking about experiences of emotional pain during the interview. This seems to be related to their feeling able to talk with others about emotional as well as physical pain. During these interviews, some male participants explained how important they were finding being able to talk with others about experiences of pain as adults.

Scheper-Hughes (1992), Lock (1999) and Scheper-Hughes and Lock (1987) point out that the body is not only both individually and collectively experienced, but it is also subject to regulation, discipline and control by social and political forces, forces which are co-constructed in these practices and discourses which occur in social interactions. These practices and discourses often take place in institutional settings. Moreover, Greenhalgh says that "for women living in a patriarchal world, the dominant discourses on subjectivity are those of femininity." (Greenhalgh, 2001, p. 42). Greenhalgh also reminds us that gender identities are not unitary, coherent or fixed. They are usually multiple, sometimes contradictory and always in process, because they are being constructed and reconstructed "in ongoing, power-laden social interactions in which the subjectivities of the parties are constantly open to contestation." (Greenhalgh, 2001, p. 43). These men and women had the school and health

care experiences which they reported in many different places in the world. Yet, gendered constructions seemed to be very similar.

The two primary types of institutional settings which participants in this study mentioned were schools and health care settings. The women and men who participated in this study had experiences in school and health care settings in many different places in the world. Yet gender-related constructions seemed to be similar. Male participants mentioned experiences which took place in school settings somewhat more often than female participants. But, women talked more about experiences in health care settings. Men, such as Kawika, Alasdaire and Sergei, sometimes portrayed experiences in school environments such as athletic fields and boys' rooms in which they learned about proper male behavior from male peers and older, male authority figures. Sergei portrayed an experience in the boys' room at school in which he was taught a lesson in behavior by another boy. Alasdaire portrayed an experience in which he was led back into a class he had been cutting by a male school principle. On the other hand, female participants such as Cathy and Jan, portrayed school experiences in which they learned embodied lessons about what it means to be female, experiences which they described as being important and lasting. Cathy described a situation at about the time of adolescence, when she was eleven, almost twelve, in which she encountered conflicting messages about showing she "can take it" because her boyfriend told her it's alright to go to the school nurse when she injured herself in school. However, Cathy portrayed a situation in which she didn't feel comfortable about going to the school nurse because this

was not consistent with her need to show she “can take it.” Jan talked about a situation in which she learned a lasting lesson about being obedient, which she describes saying, “This experience grew to matter to me only in time as the precedent for my pain experience.” Because she was actively running and playing, disobediently, she ran into a stage and hurt her knee. She said that after this she changed her view of herself and her activities. As Jan describes it, “I had become a goody-goody who only sat on the bench, not participating.”, what Greenhalgh (2001) describes as a “good girl routine.”

Women’s accounts of their experiences in health care settings and with health care personnel revolved around treatments for gender -related conditions such as childbirth and pain associated with menstruation. In these interactions, women portrayed themselves being told that menstrual pain is a “normal” part of being a woman, that they must put up with. They said they are often told that birth control pills are the only form of treatment and that, when they protest that because of the side effects this sometimes amounts to merely trading one problem for another, their protests are ignored. Finally, women say that, in these health care settings, they are sometimes treated as though they are exaggerating or making things up.

Finally, a third major finding related to place was that both female and male participants reported that the nature of the places in which they played as children affected their caretakers. There appeared to be differences across countries in the kinds of environments people played in as children. For example, Sergei, born and raised in St. Petersburg, USSR, and Cathy born and

raised in Hong Kong, described playing in enclosed areas where it was easy for their caretakers to keep an eye on them. However, several participants, both female and male, who were raised in the United States portrayed settings in their first Maps, in which they played as children, which were dangerous. Parking lots were particularly dangerous places to play which were mentioned by both female and male participants. The parking lots participants described were not only dangerous because they were paved and used by vehicles. In addition, parking lots were places where it was difficult places for caretakers to watch over the participants. Beyond this, because these were forbidden areas in which to play, participants reported being reluctant to admit being injured, since they were likely to be scolded. Another participant, Olivia, described a concrete yard in which she played as a child. She said that she fell frequently, often injuring her knees. While she said that these frequent childhood injuries were attributed to her clumsiness, it seems likely that the paved, concrete environment in which she played contributed to her injuring herself. It is a matter for concern that children growing up in the United States should report so often that the places in which they played as children were dangerous, especially since this may affect the way in which their experiences of pain are dealt with.

WHAT ABOUT GENDER?

Gender differences in the construction of experiences of pain forms a basis for this study. In this study, differences in socialization and acculturation due to gender appeared to play an important role in the ways women and men

constructed their experiences of pain. One of the most striking findings was that all the female participants said that they not only talked to others about their experiences of pain, but that talking to others is important to them in dealing with pain. Male participants usually said they preferred not to talk with others about experiences of pain.

Since women said that talking with others about experiences of pain is important and helpful to them in dealing with experiences of pain, their frequent reports that medical professionals refused to listen to what they were saying about experiences of pain are especially troubling. Discussing one's pain and, especially, one's feelings and emotions about pain, is not acceptable in the biomedical model, which emphasizes objective reports of physiological events. This reluctance to allow patients to talk about their subjective and emotional experiences of pain in the biomedical model is a reflection of the masculine values on which this model is based (Katz-Rothman, 1982). Nevertheless, once again, since it appears that participants who said they could talk about their experiences of pain with others while they were growing up also reported being able to deal with pain more easily as adults, it seems unlikely that this approach is helpful to people who are experiencing pain, especially women who prize being able to talk with others. It appears to be important that people be able to talk with others about their experiences of pain in order to have their phenomenological experiences confirmed and to form narrative constructions which help them to connect present experience to past experience in order to know what to expect in the future.

Talking with others is certainly an interpersonally oriented way of dealing with pain. However, women, in the biomedical world where unacknowledged male values predominate, are discouraged from engaging in such discourses. Greenhalgh (2001) talks about the severe costs to women's inner selves created by the sexist society in which they live. Since, traditionally, achievement in the public domain has been a male prerogative, women have been valued for their abilities to foster relationships and engage in intimate relations with others, for their capacities for interpersonally engagement. Because women's sense of self is based on fostering and maintaining close interpersonal relations with others, the possibility of separation due to aggression is threatening. In what has been described as a "psychology of relationship and ethic of care" (Greenhalgh, 2001, p.44), the good woman exercises her interpersonal skills and takes care of others, expecting to receive care and love in return. Greenhalgh argues that this gender-specific strategy is often especially ineffective and costly for women in biomedical encounters.

Greenhalgh points out that women are "doubly silenced and disempowered" (Greenhalgh, 2001, p.45) in the biomedical encounter, which is a "complex, power laden one" (Greenhalgh, 2001, p.37). As Greenhalgh states, "hierarchies of gender and power overlap in the examining room" (Greenhalgh, 2001, p. 38). The relational approach women take makes them reluctant to openly challenge or oppose the doctor, especially the male doctor, because they fear endangering the relationship on which they depend for care. Greenhalgh mentions a study in which female patients who tried to confront their male

doctors ended up feeling more powerless. Such confrontations on the part of female patients resulted in long silences in the medical interview, during which female patients could often be heard sobbing. Greenhalgh describes female patients experiencing verbal abuse and personal degradation at the hands of male doctors, as some female research participants have recounted in these interviews, particularly in their interactions with male doctors concerning pain associated with their menstrual periods. Indeed, feminists point out the role of medicine as an instrument of social control (Lock, 1999), which has become especially powerful and far-reaching through the increased medicalization of life.

Another troubling aspect of women's discussions of their experiences of pain was their tendency to blame themselves for pain. Women said that, since they should have known better or taken better care of themselves, they thought that they were at fault for their pain and deserved to suffer. They reported thinking that they did not deserve to be helped. Women also described exchanges with medical professionals who dismissed their concerns about pain, especially pain related to their menstrual periods, as unreasonable since it is "natural" for women to experience this type of pain. This might be related to the tendency to "naturalize" women's suffering connected with their childbearing functions and the connection of women with nature rather than culture. In a Cartesian mind-body construction, women are often connected with emotion, the body and nature, while men are connected with cognition, mind and culture (Good, 1994). When women talked about their experiences seeking help from medical practitioners for pain related to their menstrual periods, they reported

conversations with health care providers in which they were told that they had to expect to experience this type of pain because it is just part of being a woman. Women described their efforts to express their deep feelings about the pain and its meaning to their lives as being rebuffed by these medical practitioners. This could be accounted for by the unacceptability of emotional expression regarding the body in the discourse of biomedicine, which stresses the male values of cognition, mind and culture. It is troubling to consider the degree to which women's experiences of constructing their embodied selves can become laced with self-blame, shame and loss of power and status in such interactions.

Female participants in this study also talked about serious shifts in their gender-related experiences of themselves which occurred at about the time of adolescence and the onset of puberty. Such a shift seemed to account for the discomfort experienced by female participants when thinking of experiences to portray for their second Maps. The story told by Cathy, in which she portrays her conflicted feelings about going to the school nurse, as her boyfriend suggests, and showing she "can take it", which is important to her self-image, serves as a good example. It is important to recall that Cathy experienced a great deal of difficulty thinking of an experience of pain which occurred at about this age. However, after portraying this experience, Cathy was able to think of other experiences of pain which occurred in the age range asked about, twelve through seventeen. Describing this experience seemed to open the way for many memories of experiences of pain at the age.

Brown and Gilligan (1992), in their study of adolescent girls' development, found that adolescence marks a time of crisis for girls. They discovered that this is a time in their lives during which girls learn to silence themselves, both because the world in which they live devalues them and because they fear that conflict will result in severed relationships, which will leave them alone and powerless. While Brown and Gilligan described this in the structuralist terms of an "authentic" inner self that no longer speaks and a "false" outer self that presents the pleasant facade of what others want them to be, this study is based on a constructivist conceptualization in which self is viewed as being actively constructed by individuals out of the practices and discourses to which they have access in their environments. In this view, the self is a "situated accomplishment." Greenhalgh reminds us that "gender identities are not unitary, coherent or fixed, they are usually multiple, often contradictory, and always in process...Being constructed and reconstructed in ongoing power-laden social interactions in which the subjectivities of the parties are constantly open to contestation (Greenhalgh, 2001, p.43) and that "Gender is not only something one is, but also something one does." (Greenhalgh, 2001, p.42). As we have seen in this study, conceptions of gender appropriate attitudes and behaviors are conveyed in institutional settings such as schools and health care settings. Moreover, since they are fashioned out of available practices and discourses, identities are tied to social and cultural power structures. Women in this study often portrayed experiences involving pain which occurred at around the time of adolescence, such as those described by Cathy and Jan which took place in

settings related to school, in which they learned that they must compromise their views of themselves in order to conform to social attitudes and norms regarding what is appropriate for females in a world dominated by male values.

As Rosenwald (1992) points out, narratives and stories about one's life and who one is draw on practices and discourses which reflect societal conventions. The matter of fact, everyday quality of these practices and discourses makes them especially powerful in reinforcing and renewing already existing values. Dana Jack (1993) points out the great cost to women of the silencing of the self which begins in adolescence. At adolescence, women learn to pay attention to the needs of others, often suppressing their own needs in order to care for others. This can result in confusion about where the self leaves off and the selves of others begin. Susan Greenhalgh (2001) argues, further, that this blurring of boundaries between self and other can make it difficult for women to recognize abuse, leaving them at risk for depression and disempowering them.

Women in this study were more comfortable than men about talking about experiences of emotional pain. They even said they were interested in exploring connections between physical and emotional pain. Women did not say that they had adopted cognitive strategies to deal with the interview, as men often did. Especially because women said that talking with others about experiences of pain is important to them and that they found exploring the connections between physical and emotional pain interesting, it was troubling that women often said that they weren't comfortable about expressing their emotions regarding pain.

Women in this study seemed to have divergent feelings about expressing their emotions, describing situations in which admitting pain was viewed as an expression of weakness. Female participants, such as Olivia, described encounters in which they felt forced to choose between expressing their emotions, which would be viewed as appropriate for a woman, and maintaining status and power. Olivia said she experiences pressure not to cry because it will be interpreted as a sign of weakness. She explained that this makes her feel that she must “deny my emotions.” Cathy expressed especially clearly the loss of status and power connected with her being the older sibling which she would experience if she cried. It seems that the greater valuation given to male ways of dealing has affected these women’s comfort with expressing the emotions which they are able to feel.

The syndrome which many male participants talked about, consisting of body aches, body pain associated with muscular and joint pain, pain resulting from lack of exercise, frustration and anxiety, appeared to be related to the perception, on the part of these male participants, that body aches and muscular pains were a sign of their lack of exercise, their “lack of drive to go out there and do it”, as one male participant, Luke, phrased it. It appeared that, for many male participants, the perception that they were not actively engaging with the world and taking part in physical activity was intimately tied to their perceptions of their own identities and to their feelings of self worth. Male participants seemed to need to feel that they were physically, actively engaged with the world, especially in the form of sports, in order to maintain a positive concept of themselves.

Indeed, male participants reported dealing with pain by engaging in activity, especially sports, which one man, Jack, described as “intense, macho and very competitive and aggressive.” Men said that not only were they likely to engage in physical activities such sports with other males, but that this constituted an important mode of communication for them. In keeping with Scheper-Hughes’ (1992) exhortation to view bodily distress in terms of the inseparable, inner phenomenological experience of the sufferer, men’s constructions in regard to this syndrome seem to form a phenomenologically experienced whole, tying sensations related to pain, emotions such as anxiety and depression, activity in the physical world and issues of self and identity together.

Men’s discomfort with emotions and reports that they were more likely to engage in activities and to concentrate on things they were doing and, moreover, that they preferred to engage in activities with other men rather than talk can be interpreted in the light of recent research on male identity. This research suggests that images of masculinity in contemporary culture highlight physical toughness, emotional stoicism and self-sufficiency (Kindlon & Thompson, 1999). One quickly thinks of Finn’s stoic behavior and of his acceptance of behaviors on the part of others which promoted his physical toughness and self-sufficiency. Kawika’s account of his experience with his mother on the bike path also comes to mind. Kawika seems to be saying that he thinks his mother could have been more concerned with caring for his injury. Pollack (1998) found that this emphasis on toughness, stoicism and self-sufficiency can diminish boys’ and men’s sensitivity to the feelings and emotions of both themselves and others. In

addition, these pressures can diminish the abilities of males to be intimate in relationships. The promotion of these values and behaviors in men has been shown to have negative consequences for boys' psychological health and social behavior. Such values and behaviors do not appear to be conducive to the overall well being of boys and men (Pleck, 1995). Studies have shown that adolescent boys who internalize conventional norms for male behavior have more problem behaviors (Pleck, Sonenstein & Ku, 1994) and more difficulties with relationships.

As mentioned, male participants frequently said that they were uncomfortable talking about pain, especially emotional pain. This appeared to be related to their efforts to limit their discussions to physical pain and to adopt a plan or cognitive strategy for dealing with the interview. They also stressed that they did not like to talk with others about experiences of pain, emphasizing that they did not think people wanted to hear about pain, but about success and accomplishments. Research on masculine identity has revealed that boys ages eleven to fourteen were more willing to talk about emotions in one-on-one interviews than in group interviews (Pheonix, Frosh & Puttman, 2003). These researchers also report that, in their interviews, boys emphasized the importance of presenting themselves in public in ways which would be regarded as "properly masculine" in order to avoid being bullied and called "gay" by other boys their age.

The finding that female participants talk to others about their experiences of pain while male participants are not likely to do so, is especially interesting in

light of the finding in Chapter Five that participants who were able to talk with caregivers about their feelings when they experienced pain reported being able to deal with pain more comfortably as adults. If men are not encouraged to talk about experiences of pain while they are growing up and find it more difficult to talk with others about pain as adults, this may make it more difficult for them to deal with pain. Female participants said that talking with others about their experiences of pain is very important to them because they not only gain support but also obtain information about possible treatments and the experiences of others. In this study, male participants reported worrying about pain, while female participants rarely mentioned worrying. Males may worry more about experiences of pain because they are not able to obtain the support and information from others which women said they gain from talking with others.

Men also reported that they adopted cognitive strategies which would help them remain in control while participating in the interview. As Jack and Finn revealed in Chapter Five, men frequently said that they had adopted a strategy, a sort of cognitive plan, to deal with this interview when they heard it was about pain. Male participants explained that they used such a strategy when they realized that the interview concerned pain because this is a topic which is likely to involve emotions and they thought they would not be comfortable discussing it. However, during the interview, when they were given the opportunity to talk about experiences of pain, male participants seemed to seize this opportunity and use it to explore areas, such as emotionally painful experiences, which they did not usually have a chance to discuss. Some male participants appeared to

experience discomfort at being asked to talk about experiences of pain, yet, upon completing the interview, said they had found it interesting and helpful to think about their experiences of pain. Some male participants even expressed interest in taking a different view of pain. The willingness of male participants to engage in this long interview on pain may be related to the finding in the study that participants who as children had caretakers who talked with them about their experiences of pain, appeared to be more comfortable dealing with pain as adults. Since our experience of our embodied selves is constructed in interaction with others, opportunities to talk with others appear to provide valuable sites for constructions of self which help in dealing with experiences of pain.

Hegemony

Both female and male participants in the current research appear to experience and construct their experiences of their bodies in pain based on the practices and discourses in which they are asymmetrically included based on gender. Both women and men appear to encounter difficulties in dealing with their experiences of pain because of the constructions imposed by the gendered practices and discourses which they experience. The concept of hegemony seems useful in elucidating participants' experiences.

Anthony Chen (1999) explains that an essential component of the concept of hegemony is, consistent with the social constructivist perspective (Holland, 1997; Lock, 1999), the idea of positions of differential power from which members of a culture, including both women and men, struggle to negotiate

prevailing conceptions of reality, including definitions of what constitutes masculinities and femininities. Also in keeping with the social constructivist position, the concept of hegemony captures the idea of a process, which extends over time and involves interactions in which participants exercise unequal power, through which a view of reality is established. This view suffuses everyday understandings and constructions of reality, becoming so readily accepted that it seems “natural”. Chen reminds us that a key theoretical concern in the “new sociology of masculinity” (NSM) has been an increased understanding of the hegemonic power relations among men and between women and men. He also reminds us that “masculine” and “feminine” are no longer viewed as singular positions or static, homogeneous objects which can be neatly labeled “feminine” and “masculine”. The plural terms “masculinities” and “femininities” signify the new perspective on gender as “multifaceted, dynamic process suffused with power relations” (Carrigan, Connell, and Lee, 1985, p. 181).

As Gramsci points out, such a deeply ingrained view of “reality” ensures the consent of the oppressed to their own oppression both because they participate in the construction of this shared view and because the processes of construction are invisible, making it seem as though this is how things “naturally” are (Gramsci, 1971, p. 326). Hegemony in regard to gender is propagated through ideas about what women and men are “naturally” like because of biologically based, immutable differences. Thus, a key component of the concept of hegemony is that domination is achieved not only through externally imposed coercive power, but also through an unwitting acceptance of a view of

the world held by the rulers.(Fiori, [1970], 1990). Thus, hegemony refers to a form of domination in late capitalist societies that “is characterized by a combination of force and consent” and that “is used to put forth a view of the world to which both oppressor and oppressed submit”. (Gramsci, 1971, p.80). As has been demonstrated in this study, cultural institutions, such as schools and health care settings, participate in promulgating these views. Chen emphasizes that the ways in which both oppressor and oppressed buy into hegemonic discourses has been de-emphasized. Emphasis has been placed on understanding the role coercion plays in imposing conceptions of the masculine and feminine rather than on the ways in which women and men themselves engage in discourses which promote hegemonic distinctions and power relations.

In the present study, both women and men seem to be suffering from the ways in which they construct their experiences of pain based on hegemonic practices and discourses. Men were often worried about experiences of pain. Their discomfort at talking with others about experiences of pain appeared to isolate them. They were especially uncomfortable talking about and dealing with emotional experiences of pain. Their concern with control and discomfort with emotion inclined them to try to adhere to strictly physical aspects of pain, leaving much of their experience of pain unaddressed.

On the other hand, the emphasis on male ways of experiencing and constructing pain appears to dominate the current, official biomedical discourse. The biomedical construction of the body sternly bifurcates physical from emotional pain, emphasizing the physiologically based facets of painful

experiences (Lock & Gordon, 1988) and preventing people, both female and male, from expressing their feelings about their experiences of pain in biomedical settings. As the constructivists argue, male activities and values are overemphasized in the biomedical discourse (Holland, 1997), with more power accorded to the male view. Thus, in this study, women were more comfortable talking about emotional aspects of pain and were interested in exploring their connection to physical pain. However, women communicated ambivalence about expressing their feelings about experiences of pain, saying that they sacrificed status and power, and appeared to lower their own views of themselves, when they admitted pain, especially when they cried. In addition, women often talked about medical practitioners who wouldn't listen to them, considering talking about pain, especially expressions of emotion regarding experiences of pain, inappropriate and devaluing their accounts of their experiences of pain.

Moreover, this study raises a serious concern. Participants in this study who did not have people who would listen to their feelings regarding their experiences of pain tended to have a more difficult time dealing with pain. Could the way the clinical, biomedical discourse encourages people to construct their experiences of pain be making pain harder for patients, both female and male, to deal with?

PAIN AS A MAJOR EXPERIENCE IN THE CONSTRUCTION OF THE SELF:
WHAT HAS THIS STUDY CONTRIBUTED TO A BIOPSYCHOSOCIO-
CULTURAL MODEL?

The finding that participants were not able to adhere to a firm separation between physical pain and emotional pain was surprising. This result was even more startling because even those participants who said that they intended to separate physical pain from emotional pain were unable to maintain this distinction. What makes this finding so surprising is that physical pain is separated from emotional pain in the expert discourse of biomedicine, which is a dominant discourse in contemporary culture, one which can be viewed as a “master discourse.” The dominance of this discourse would lead one to expect that it would exert a powerful influence on participants’ constructions of pain, in keeping with what Giddens (1991) termed the “reflexivity of the institutions of modernity”, the power of expert discourses to influence people’s constructions of their experience in everyday life. Many theorists working in the field of pain, such as David B. Morris (1991) have suggested that, because of the dominance of the biomedical discourse, both women and men, should be expected to construct their experiences of pain in terms of physical pain, bifurcating other experiences of pain, particularly emotional pain and perhaps also “social” pain, into other discourses, or leaving them silenced and voiceless (Morris, 1991). Yet, all the participants in this study went beyond the structure determined by the biomedical discourse in constructing their experiences of pain in everyday life, eliding their

experiences of physical and mental pain and tying these experiences to many aspects of their lives.

As I worked with the participants during the interviews themselves, and later, as I analyzed the data, I was impressed by the important role pain seemed to play in people's constructions of both their lives and of their embodied "selves" (Csordas, 1990, 1994). Participants not only thought with ease of experiences of pain which took place when they were ages six through eleven, but they often told me that these were important experiences in their lives, sometimes without being able to explain why they found them so notable. However, some participants were able to explain the complex connections embedded in such experiences. For example, Kawika explained that he injured himself while riding a bike on a forest path, hurting his leg. However as he elaborated on the scene he depicted, it became clear that this "embodied experience" was connected to many aspects of his life at the time, and to his emerging sense of self. He was riding on the path because his mother wanted to go swimming, an activity about which he, as "a land animal" is less enthusiastic. He wanted to wear long pants, but his mother had kept him in short pants, a battle over age and status which, Kawika said, resulted in his not only injuring his leg, but also acquiring a permanent mark, which " wouldn't have happened if I had been wearing long pants". Cathy, in her first Map, depicted a similarly dense experience in which it was important, even though she had injured herself, that she not cry because she would lose some of her status as an older sibling, the favorite of her beloved father, in front of her younger brother. Yet, this was an occasion made

memorable to her by the fact that she did cry, because a small dog came to her and licked her face.

Female participants talked about the power of experiences of pain to help in forming connections to others and in promoting growth at many points in their lives. For example, Bianca stressed that experiences of pain provided opportunities to strengthen connections with others. She also said that pain often lead to insight and growth. I began to think that, although the issue of pain has been dominated, and, perhaps, even usurped, by the biomedical discourse, experiences of pain are such essential events in making meaning of human life that they elude the power of the dominant biomedical discourse to contain them.

A major reason for undertaking this research is that the topic of gender differences in the construction of pain appeared to present a uniquely appropriate entry point for the investigation of a biopsychosocio-cultural model of human health and illness. Pain has become a highly problematic issue in biomedical discourse and practice, where patients' pain has often been regarded as a biomedical "problem", a difficult matter, recalcitrant to treatment. In addition, pain appears to challenge the basic epistemological orientation of the biomedical model, that human health and illness are determined by objective, physiologically-based occurrences and that these occurrences can be investigated objectively, without considering the subjective, phenomenological experience of the person in pain (Good, 1994). The results of this study reveal that pain is an essential, and even crucial, part of people's daily experience. In conducting this research, I became increasingly persuaded that it is not possible to reduce experiences of

pain to a problematic issue in biomedical practice because pain appears to be a key human experience which provides a nodal point for the creation of meaning and self in human life.

Elaine Scarry's (1985) discussion of torture, in her brilliant book, "The Body In Pain", makes the important point that the experience of pain disconnects people from the usual resources and ways of meaning-making on which they draw in the course of normal, everyday life. Scarry describes how the power of pain to disconnect people from the cultural tools they use in creating meaning in their lives makes pain the ideal tool for torture because the torturer, by inflicting pain, severs the torture victim's connections to his social and cultural worlds. The victim of torture, cut off from the social and cultural resources on which he draws to construct his sense of self and meaning in his life, becomes open to the new constructions of self and the world which the torturer imposes on him.

The results of this study suggest that even the experiences of pain which participants undergo in the course of everyday life have the power to momentarily sever their usual, ongoing connections to their social and cultural worlds, to sever assumptions about who they are, what the world is about, and how they fit into this world. For this reason, it appears that experiences of pain serve as nodal points in constructions of the self and the world. It is at moments of pain, when people must reach out for cultural tools and resources, that people learn essential lessons about who they are and how they fit into the world. Because of this, even experiences of pain which occur in the course of everyday life appear to be fundamental experiences in the construction of human lives.

My burgeoning realization of the key role pain plays in everyday constructions of life was spurred on to further elaboration when a surprising experience occurred during the early stages of the data analysis. Dr. Suzanne Ouellette, a member of the dissertation committee, was listening to Jan's story of the role pain had played in her life and suggested that Jan's story reminded her of Arthur Frank's (1995) description of what he termed the "Chaos Narrative". I found this suggestion surprising because Frank was describing a type of narrative which people construct when their lives are disrupted by illness. However, the participants in this study had been carefully screened to assure that they did not have any difficulties with pain which fit the medical criteria for chronic or clinically significant pain. According to the medical definition, Jan had a "normal" experience of pain. Why would she employ a type of narrative structure that resonated so convincingly with Frank's description of narratives which people employ when they experience life disrupting illnesses?

Briefly, Frank (1995) identifies three types of narrative structures which are employed by people who are experiencing severe, life disrupting illnesses: the Restitution Narrative, the Chaos Narrative and the Quest Narrative. The Restitution Narrative is, essentially, a biomedical narrative, according to which everything is going to return to normal. While it is true that the person has been ill, the source of this illness has been, or will shortly be, identified, at which point everything will return to its original state of "normalcy." Frank explains that this narrative is exemplified by statements such as, "Everything is fine now." and "But, I'm fine."

However, Frank goes on to explain that the second type of narrative, the Chaos Narrative, is not really a narrative construction at all, but the voice of someone who has not yet been able to resume “selfing”, which Frank defines as the ongoing process of construction of the self. Frank describes these narratives as being told in an ongoing, timeless present, characterized by repetition of the phrase “and then, and then.....and then”. People telling Chaos Narratives have difficulty connecting present experience to past experience and can derive no sense of what can reasonably be expected in the future, an essential role of the narrative construction of human experience. Jan herself explained that her life is dominated and disrupted by pain because she never knows what to expect. Frank also explains that, in the Chaos Narrative, there is a dearth of evaluation of experience, evaluation being an essential meaning-making activity. Jan has difficulty evaluating her experiences of pain, difficulty connecting them to the rest of her life, unlike Cathy and Bianca, for whom experiences of pain are less troubling.

Finally, Frank describes the Quest Narrative, which is a narrative constructed by a person who realizes her life is not a Restitution Narrative, everything is not going to go on as before, but who has emerged from the Chaos Narrative, in which meaning making has been eclipsed, and is now trying to continue the work of “selfing”. Frank says that, “ the communicative body is told in Quest stories” (A. W. Frank, 1995, p.126). Quest narratives are characterized by an openness to contingency and the realization that “contingency is the only real certainty” (A. W. Frank, 1995, p. 126) The person developing a Quest story

realizes that what might appear to be an interruption can be understood as an opening . One thinks of Cathy and Bianca. Cathy admits that she fell and hurt herself, and did so often, as a child playing in her family's compound. However, she explained that, because adults were always there to help her and were willing to listen to her, she never worried about falling and hurting herself, although she knew she would fall sometimes. Because she was able to engage in practices and discourses with others, she was able to use cultural tools to connect her inner experience to the larger culture. She, like Bianca, was able to accept contingency, which left her feeling relatively comfortable that she would be able to deal with the disruptions caused by experiences of pain, that she could use them as openings rather than as the frightening disruptions, which Jan experiences.

If experiences of pain constitute nodal points in the construction of self in everyday life and are key experiences in the "selfing" process (A. W. Frank, 1995), this points to the importance of a biopsychosocio-cultural model of human health and illness in understanding and dealing with the human experience of pain. Such a model takes a broader view of human health than the biomedical model, dealing with health as well as illness, which is the focus of the biomedical construction. It also rejects the mind-body duality of the biomedicine. A biopsychosocio-cultural model can take into account and integrate micro-level processes such as the biological, physiological and psychological with macro-level processes such as social and cultural forces. Such a model offers ways in which to help people deal with pain which go beyond the possibilities offered by

the biomedical model. Beyond this, this study has taken an environmentally-oriented, embodied, phenomenological stance which has allowed for a consideration of the actual practices and discourses which participants draw upon in constructing their experiences of pain. The ubiquity and richness of these practices and discourses point to their importance. Returning to my experience in the group therapy session at Bellevue Hospital/NYU Medical Center, I can now address the question I raised, "Why wouldn't people have words for their emotions and why would not having words for one's emotions have anything to do with drug abuse?" It seems likely that being able to engage with others in meaningful practices and discourses which help one to connect one's inner, phenomenological experience with the values and norms of the society and culture in which one lives is essential to constructing an embodied self which is healthy.

Participants in this study did draw on the practices and discourses differentially available to them in their cultures based on their embodied standpoints. The positions in society and culture which were open to them proved to be heavily affected by gender. The results of this study show that women and men had access to different practices and discourses in their constructions of their experiences of pain. A biopsychosocio-cultural model of health and illness provides ways both to account for the different effects on embodied experience which result and to address these experiences. In particular, a biopsychosocio-cultural approach offers possibilities for treatment which would allow conversation which can open up ways for both participant and

health care practitioner to understand the embodied experience of the person in pain.

A biopsychosocio-cultural model also allows for an examination of the values inherent in treatment, which may appear “natural”, but which are the result of differential power and hegemonic practices. Such hidden, “naturalized” values may not only prevent effective treatment, but may contribute to and exacerbate the individual’s experience of pain. In this study, both women and men appeared to encounter difficulties in dealing with their experiences of pain because of the constructions imposed by the gendered, hegemonic practices and discourses which they experience. The women in this study encountered male doctors who refused to pay attention to their concerns over pain accompanying their menstrual periods offer one example. The silenced discourses of male participants, such as Jack, who engaged in athletic activities with other males in the face of painful and severe injuries offers another. As Scheper-Hughes (1992) and Lock (1999) and Scheper-Hughes and Lock (1987) point out, the body can be both individually and collectively experienced and is also subject to regulation, discipline and control by social and political forces.

Finally, a biopsychosocio-cultural model offers a way to address Margaret Lock’s (1999, p.44) concern that “Illness episodes must be integrated in the broader context of human relations. Only then can insight be obtained into how social relations can produce illness and how the body functions, consciously and unconsciously, as a medium for the expression of distress, a subjective experience itself culturally mediated.” From a biopsychosocio-cultural

perspective, people's experiences of pain can be understood as pivotal experiences which draw upon and connect many experiences, relationships and values in their lives. The biomedical model relegates experiences of pain to physiologically based phenomena which are difficult to connect to life experiences.

However, the data from this study suggest people may resist and even struggle to overcome the duality inherent in the master discourse of biomedicine. It appears that, in everyday experiences of pain, the physical and emotional are so powerfully and inextricably intertwined that people work to link them in order to make the connections essential to their ability to function in and make meaning of everyday life. Dominant, master discourses which, based on Cartesian mind-body duality, bifurcate "physical" from "emotional" experience seem to result in discontinuities in participants' constructions of their own experiences of pain. Viewed from the vantage point of participants' own, lived daily experiences of pain, pain appears to occupy a role that is much too central to people's experiences of their "embodied selves", their understanding of the world and of their place in it, to be marginalized and relegated to a peripheral status in the domain of medicine.

If the dominant biomedical discourse does not provide for participants' constructions of their "selves" through their experiences of pain, it is possible that, in the process of constructing stories of their lives as part of the work of constructing a "self" (Rosenwald, 1992), it becomes necessary for people to challenge and, ultimately, to resituate, the dominant discourse of biomedicine.

**RESITUATING DOMINANT DISCOURSES: PAIN AS A SITE FOR SELF
CONSTRUCTION. MASTER DISCOURSES AND PERSONAL EXPERIENCES
OF PAIN IN POSTMODERNITY**

How can illness episodes can be “integrated in the broader context of human relations”, Lock (1999, p.44) it)? Holland (1997) and Rosenwald (1992) describe the ways in which people operating from positions of unequal power negotiate the values and meanings which will be accepted and which will dominate a culture and society. Moreover, they argue that this constant negotiation on the part of people with unequal power makes change inevitable in any society. Rosenwald (1992) describes how socially available practices and narratives play a significant role in the formation of identity because personal life stories draw on societal conventions. He also points out the problem this view poses, that it makes it difficult to account for personal agency and social change. However, Rosenwald presents a solution to the problems of agency and change, saying that the individual’s story is not entirely subsumed by the extant social values, practices and discourses. The text is not all there is and individual compliance with dominant practices and discourses is never total. The stories told by an individual represent a compromise between the teller’s desires and goals and the constraints imposed on these desires and goals by the dominant social practices and discourses. When the individual’s desires and goals become too severely compromised and when these compromises become problematic for the teller in dealing with her or his daily, lived experience, the

narrator is likely to risk violating these social and cultural “models of intelligibility” (Rosenwald, 1992, p. 266).

Consider, again, the interview with Jan. I experienced some ethical concerns about reporting her interview, because it seemed that she was having a very difficult time with pain. I didn’t want to portray her in a negative way, especially since my experience of her during the interview was not negative. While I was sometimes confused by what Jan was saying, I experienced her as a person struggling to come to grips with a deeply troubling aspect of her life. My sense of her was that, in pursuit of some understanding of her troubling experiences with pain, she was willing to become engaged in the interview and to complete it. She seemed to be trying to use the interview to explore, as much as possible, her own troubling, life-disrupting experiences of pain. In this, she was like many of the other participants who appeared to use the interview as an opportunity to explore. However, I also realized that, within the dominant, biomedical discourse, it was difficult to convey this view of Jan. If I adhered to the biomedical discourse, it was going to be difficult to avoid portraying Jan as a troubled person who was not able to deal “appropriately” with her experiences of pain.

However, if experiences of pain are viewed as nodal points for the construction of self, then Jan’s openness to participating in the interview can be viewed as a sign of willingness to engage in the “selfing” process (A. W. Frank, 1995). Considered in this light, Jan no longer appears to be a helpless victim. Because of the constraints on the discussion of experiences of pain in our

culture, there are few other venues available to Jan in which she can discuss experiences of pain, possibly finding ways to resituate her own discourse. In Rosenwald's terms, Jan is struggling with the practices and discourses available in her culture. In order to make sense of her troubling experience, in which she describes her desires and goals as being compromised by conforming to narrative expectations, she appears to be experiencing a great deal of tension. Possibly, if the compromises necessary for conforming to narrative expectations become sufficiently taxing, she will risk violating the social and cultural "models of intelligibility" (Rosenwald, 1992, p. 266) into which she is already having difficulty fitting her experiences.

I detected and reported tensions in the stories told by several participants. This, along with participants' frequent comments that we seldom discuss experiences of pain in everyday conversations in our culture made me wonder whether, if we were to discuss our experiences of pain more and make such discussions possible in more different settings in our social and cultural worlds, we might open the possibility of re-situating both the dominant discourses and our own voices. The Interview Protocol itself seemed to serve as a useful tool in helping participants explore their experiences of pain.

The stories told by many participants contained "tensions" between accepted social practices and discourses and the desires and goals of the research participant. In considering these "tensions" I was reminded of a piece I had read by Harriet Bjerrum Nielson (1996) in which she addresses the issue of tensions in people's stories. Bjerrum Nielson argues that it is necessary to trace

the “black holes” in people’s narratives in order to understand the use individuals make of the established discourses in processing the emotional tensions in their lives. Her work offers some additional insights into the role of pain as a site for self construction. She, like Rosenwald (1992), states that, in the aftermath of structuralism, “agency” is becoming one of the most highly valued terms in the social sciences. As Rosenwald (1992) explains, social science researchers have become aware of the importance of viewing the subject as an active contributor to the formation and transformation of social structures and cultural forms. This shift in interest toward the “authoring self”, has increased the research attention being devoted to the actual, lived experience of everyday people through the use of ethnographic studies of everyday life, in depth interviewing, life stories and autobiographical approaches. However, both Rosenwald and Bjerrum Nielson contend that we need a theory of the agent in order to construct a notion of agency. In order to develop a theory of the agent, Bjerrum Nielson advocates exploring the fascinating question of how humans process and act on their experiences of life, not only in conscious, but also in unconscious ways. She urges us not to ignore the role of deep motivation in the formation and transformation of culture. Bjerrum Nielson’s thoughts on investigating unconscious processes in the texts people produce offers a way of investigating the “tensions” in these interviews.

To investigate these “tensions” or “irritations” in people’s stories, Bjerrum Nielson emphasizes the importance of looking at “life forms in the making”. She argues that it is necessary to consider both the conscious and unconscious ways

in which humans process and act on their life experiences because interpretations of texts that leave out the psychological/emotional level of textual organization limit researchers' abilities to understand how individuals contribute to social and cultural change. Certainly, this seems pertinent to accounts of pain in everyday life presented by participants in this study. Interpretations which remain on the level of cultural configurations can yield valuable insights into how people actually use cultural concepts in organizing and making sense of their social worlds. Such interpretations can also provide important information about which cultural discourses are available to whom, who uses them and when, an important aspect of the present research. However, Bjerrum Nielson maintains that it is necessary to develop a theory and a method for grasping how small, personal histories are constantly acting to change the larger discourses in order to investigate not only how people make use of cultural concepts in constructing their "selves" and their social and cultural worlds, but also how their personal constructions affect social and cultural discourses, contributing to cultural change.

As Rosenwald (1992) explains, people's narratives have a "double relevance". They are not only about the life, they are also part of the life. This gives them a "cognitive and motivational power to transform lives" (Rosenwald, 1992, p. 271). Because of this "double relevance", narrators struggle to tell their lives in ways that help them to live their lives, to move on with their lives, sometimes necessitating that their stories challenge the accepted discourses and practices of their society.

Like Gananath Obeyesekere (1990), Bjerrum Nielson argues that considering and reading the unconscious should not be viewed as off limits to all but psychoanalytic clinicians. She maintains that a consideration of motivation is essential to all researchers whose aim is to understand the work of culture. Otherwise, she warns, an anthropologist is placed in the position of either denying that unconscious materials exist, or saying that, while they may exist, they do not manifest themselves in either cultural forms or social life. In Obeyesekere's view, the only alternative to such a neglect of the unconscious is to find a theory that will help the social science researcher to investigate and understand unconscious material. Without a theory that aids in the investigation of unconscious materials, social science researchers will "leave a large area of symbolic form and social life uninvestigated" (Obeyesekere, 1990, p. 223-224).

It has been argued that when "grand narratives" lose power, little narratives, like autobiography, gain credibility (Gullestad, 1996). Gullestad claims that the art of moral living in our postmodern time is the art of living with tensions, contradictions, dilemmas, paradoxes and ambiguities, trying to find solutions in terms of integration rather than in terms of either/or solutions. However, Bjerrum-Nielson objects to her explicit exclusion of psychoanalytic interpretations and theory, because, Gullestad claims, such psychoanalytic interpretation "reduces the imaginative and reflexive qualities of the autobiographic account to 'distortions' of deeper meaning..." (Gullestad, 1996, p.7).

Bjerrum Nielson draws on Paul Ricoeur's view of life as "an activity and a passion in search of a narrative" (Ricoeur, 1991, p. 29) to highlight what a reading from a psychoanalytic perspective can add to a cultural analysis, especially in regard to the question of agency. In Ricoeur's view, similar to Rosenwald's (1992), the construction of a narrative can be viewed as the production of a textual structure that "underscores the mixture of acting and suffering which constitutes the very fabric of life. It is this mixture which the narrative attempts to imitate in a creative way". (Ricoeur, 1991, p. 28). Ricoeur advises looking for both the points of support that the narrative can find in the living experience and the points that express the need for the assistance of a narrative. From this standpoint, the motivation necessary to the creation of a text comes not only from a desire to make sense of what goes on around the narrator, but also from a desire to make sense of the unconscious passions and sufferings within the narrator the desires and goals which may be compromised in constructions using socially and culturally accepted practices and discourses. In short, we tell stories not only to make our lives more intelligible, but also more bearable. Since we do not have control over all the physical and social elements of our lives, although narratives may strive toward homogeneity, they are, of necessity, a synthesis of discordant, heterogeneous elements (Rosenwald, 1992).

Bjerrum Nielson introduces the ideas promulgated by researchers in the Frankfurter School, including Arthur Lorenzer (1986), who developed a method of " deep hermeneutic cultural interpretation". This method provided a theoretical

frame within which both the conscious and unconscious structures of meaning in a text could be understood. Based on this theoretical orientation, the aim of interpretation was not to reduce the manifest meaning of a text to its latent meaning. From the theoretical perspective of these researchers, the unconscious structure of a text was not something lying behind the text, but another kind of structure of meaning within the text itself. To support this claim, Bjerrum Nielson compares a dream with a text. She points out that in order to explore the latent meaning of a dream, it is necessary to ask the dreamer for additional information. However, this is neither possible nor reasonable in the case of a text. The latent meaning of the written text must be present in the text. This means that the connection between the unconscious and the conscious in a text must be present in the symbolic accounts themselves.

Bjerrum Nielson argues that these coexisting structures of meaning are not only present, together, in the written text, but that these structures of meaning are related to each other in many ways. One way is that the unconscious structure softens the contradictions of the conscious structure. For example, in the current research, such efforts to soften contradictions appeared to be evident in the interview with Finn as he tried to make sense of his experiences of pain. At first, he seemed to ignore the contradictions in his own presentation of his story of becoming severely ill on the remote island off the coast of Canada where he usually visited his grandparents in the summer. He explained that, even though he was quite sick with a bad strep throat, his grandparents delayed seeking medical attention because the island was so small and remote that there were no

doctors on it. At first he adhered to this conscious structure, asserting that he eventually became so sick that he was unable to attend school for six months while he recuperated at home, only because of unavoidable, external factors, attributing his prolonged illness to “Bad luck. Bad timing. Wrong space. If it was the ‘normal environment’ it would have been caught much sooner, before it ‘dominoed’ into other things.”

At first, the unconscious structure prevented him from seeing the contradictions in his story, which he himself mentioned, such as that there were telephone lines which could be used to call a doctor on the mainland and that, eventually, he was taken to the mainland for treatment. However, slightly later in the interview, these unconscious structures appear to break down to some extent. At this point, Finn says, “I just thought, ‘Why has fate done this to me?’” Next, Finn shifts perspectives slightly, saying,

There’s got to be some glimmer of self pity, more at the time. It stunted my puberty. For the whole next year. I probably didn’t get into real adolescent changes until I was over fourteen... I feel self pity. It was hard not to be in school...

Here, the unconscious structures appear to be losing their ability to soften the conscious structure of this story. Shortly after this point in the interview, the tone of the interview changed. Finn seemed to grow more remote and less friendly. When the previous, friendly, engaged tone of the interview reappeared, Finn began to re-examine his experiences and ways of dealing with pain, speculating much more overtly on whether he and others around him always took good care of him.

On the other hand, Bjerrum Nielson notes that the conscious structure may soften the forbidden nature of the unconscious structure. One particularly good example of this occurred in the interview with Jan. Several times, Jan began to talk about subjects which appeared to make her uncomfortable. At points in these stories, she would seem to be skipping key pieces of information, making the story seem as though it didn't "hang together". For example, when Jan was discussing her recent experience of back pain, she introduced the idea of an "extra stressor". Somewhat unexpectedly, this "extra stressor" turned out to be a fifteen-month old child, whose identity was not explained further. Next, Jan jumped to saying "Just after hearing that I was going to be promoted. It would have been wonderful." Here, the meaning of "it" is somewhat ambiguous. She follows this by saying that the back pain recurred then, without explaining further, with the observation, "I was just promoted and I felt like I'd never walk again."

The researcher was left to "fill in the blanks", which seemed to revolve around Jan's very brief mention of "family obligations", which might provide a clue to a possible link between these disparate elements. Jan did this at several points in her interview, leaving the researcher with the overall impression that Jan seems to recall many circumstances which occur in her life at the same time as experiences of pain, but that these co-occurring circumstances do not serve as organizing principles. It seems possible, based on Bjerrum Nielson's conceptualization, that forbidden thoughts are trying to emerge, but remain constrained by the conscious structure, which revolves around experiences of

pain. This is in contrast to many sections of Cathy's interview, in which she usually makes the connections she forms between life circumstances and experiences of pain explicit. For example, she tells us the family compound was a place where many adults spent their time, making them readily available to help if she or her brother was injured and in pain. She explained further that this made them feel comfortable that they would be helped, allowing them to play freely wherever they liked in the compound.

Bjerrum,-Nielson also argues that, because of these multiply related, coexisting structures of meaning, a text can be the vehicle for presenting forbidden passions in a public arena. These multiply related structures of meaning can also make it possible for the text to present "alternative life sketches" to the reader. Jan does this at times. The example presented above is one instance of this. In what she does say, she offers a different view of what her life could be like. When Jan says, "It would have been wonderful", she is briefly sketching an alternative life. Reading between the lines, it is possible to imagine that she is suggesting the possibility of a life in which she could have been promoted at work and simply enjoyed the experience. Perhaps her family could have joined in, wishing her well and refraining from asking for the usual amount of assistance with domestic matters to allow her time to enjoy contemplating the new position she has attained in her work life. Thus, Jan is using the interview, to some extent, to present forbidden themes and to suggest possibilities that intrude on forbidden areas.

Obeyesekere (1990) makes a similar point in his discussion of “personal symbols”. He argues that, by engaging in cultural practice, a person can enact personal conflicts. However, in doing this, the person is mediating this conflict and connecting it to the realm of culture. The person’s action is intelligible to others, although they may be totally unaware of his unconscious motivations for engaging in these behaviors. Obeyesekere argues that this is the way in which personal symbols come to act as a mediating language between a privatized language, in terms of symptoms, and everyday, communicative language. Moreover, in the process of connecting these two structures, both may be changed.

Once again, we can return to one of the initial questions which motivated this research, the question of why a person who did not have words for emotions would display “symptoms”, such as substance abuse. Bjerrum Nielson’s ideas suggest a way to view “irritations” in people’s stories as possible sites for self construction, places in the person’s life story where narrative compromises are becoming sufficiently costly to personal desires and goals so that the person will risk violating the social and cultural “models of intelligibility” (Rosenwald, 1992, p. 266) of accepted practices and discourses. It seems likely that, on the day I attended the group session conducted for patients with substance abuse problems, the highly articulate man who refused to conform to the accepted discourse of the group in describing his feelings when he needed to take a drink, was a such a point. In Obeyesekere’s terms, he was speaking very nearly in his privatized language, but, in opening this private world to the public gaze, he may

have been moving toward a mediating, communicative language. As Obeyesekere points out, both his privatized language and the everyday, communicative clinical language regarding substance abuse might have been changed, had the process been engaged.

According to Obeyesekere (1990), Ricoeur (1991), Lorenzer (1986), and Freud (1918), by mediating between the realms of privatized language and everyday, communicative language, personal symbols can help to control loss and help one to bear or even control or relieve suffering. A determining factor in whether transformation takes place seems to be the degree of symbolic remove. From this perspective, the distinction between a symptom and a symbol is that, while both contain both motive and meaning, “a symptom is under the domination of motive, a symbol is under the rule of meaning”. (Obeyesekere, 1990, p. 12). Thus, Jan concentrates on symptoms of pain, which wield a powerful force over her life. Conversely, Cathy and Bianca are usually, although not always, able to connect their experiences of pain to the rest of their lives in meaningful ways, which appears to make them more comfortable in dealing with pain.

Bjerrum Nielson cites Lorenzer (1986), who advocates being open to a text and listening to it, noting where it “irritates.” These are places where something does not seem to fit, something seems to be missing, the text becomes contradictory or, on the other hand, seems overly coherent (Prokop, 1996). What is being said may be experienced as “ambiguous”, “touching” or even “untrustworthy”. While these feelings may be aroused by the content of the

text, they are more often a matter of form, such as selection, ordering, rhetorical figures, textual images. We sense these “irritations” because of our experience as human beings and because of our knowledge of a culture.

In this study, both of the stories Cathy tells while drawing her two Maps display these slight irritations. While drawing the first Map, she emphasizes themes of receiving help and support from adults in her family, especially her father and mother. She explains the issues of status and power involved in her being the first born and, as a result, her father’s favorite. She also explains that it is important that she not cry in front of her younger brother because she risks losing the status and power of being the elder child. She tells us that she must show that she “can take it” and not cry. However, she also tells us that the reason she remembers this particular incident is because the small dog she portrays in her drawing came to her and licked her face. As a result, she did cry. She does not emphasize this point, nor does she make any effort to explain or soften this discrepancy. I was not even sure that she noticed that this story, in its essence, belied her overall portrayal of herself and the ways of dealing with pain which were important to her at this age. This was an “irritation” in her story, one that, on the face of it seems rather blatant, but which, in the context of her interview, was difficult to observe. She didn’t emphasize this point. It just seemed to slip past in the interview. Yet, her selection of elements for the story and the order in which she presented these conflicting ideas created a subtle “irritant” in her story.

When Cathy told the story of the scene she depicted in her second Map, these “irritations” became more noticeable, partly because she expressed so much discomfort at being asked to think of an experience of pain which occurred during this period of her life. When, after portraying this experience, she went on to say that she could, suddenly, think of many other experiences of pain which occurred in the age range asked about, this also drew attention to her initial difficulties in recounting an experience which occurred within this age range. Within the story itself, there were “irritations”. While she maintained that it remained important to her to show she could “take it” and not cry, not go home from school when she was injured, she also said that she did, eventually, go home. In addition, she mentions that the boy she liked at the time told her that it was alright to go to the nurse, although she initially thought “it was too embarrassing to go to the nurse. People would talk about it.” Although she did go to the nurse, eventually, she did show that she could “take it” by not going home early. Her story contains “irritations” and conflict.

According to Lorenzer, unconscious forms of interaction tend to have a “scenic character”, consisting of complexes of different sensations, which, because of this, can only be conveyed in the text by scenic representations. In this study, consider Luke’s own description of the scene he chose to depict in his first map, which he explained remained vivid for him for many years because he didn’t understand what it meant. However, he said that, when the meaning of this scene became clear to him, that his mother was concerned about a pregnancy when she was in the midst of a divorce, the scene lost its vividness,

although it remained as an important memory. Bianca also explained that her memory of the scene she depicted in her first Map was vivid. Like Luke, she said that she didn't understand the meaning of the scene. Also like Luke, she said that she knows this is an important memory. However, unlike Luke, she said that she still doesn't understand the meaning of this scene, a scene which retains its vividness for her. Yet, when she talked about this scene, she seemed to be talking about gender, about her difficulties adjusting to the birth of a baby brother, because "boys are so different". It seems possible that she remembers this scene because it represents a situation in which she was able to help her baby brother through reaching for his pacifier. This act, in which she possessed greater power and was trying to help her dependent baby brother, may have represented a moment when she was able to come to terms with the birth of her new brother. She concluded her story by asserting that now she and her brother get on well together. Obeyeskere (1990) talks about how personal symbols are tied to life in a way that makes them primarily non-verbal, saying that it is "their collective representations which will give them more verbal embodiment".

Considering these "irritations", multiply related structures of meaning in which unconscious structures soften conscious structures and conscious structures soften the forbidden nature of the unconscious structures, it appears that in this study, participants did use the interview as an opportunity to struggle with the boundaries imposed by gendered, hegemonic discourses, to try to push their constructions of their life experiences beyond the strictures of the master discourse of biomedicine, which separates pain from life and attempts to reduce

it to a physiological entity. Rosenwald (1992) also argues that life stories display the mediation between the person and the situation. Because neither can be reduced to the other, narratives and life stories reflect critically on both the person and the situation. Moreover, Rosenwald, in his idea of “double relevance” asserts that life stories are not necessarily about accurate representation of the life, but are meaningful to people’s lives because they play an important role in the life, offering impulses to future development. Jan has difficulty opening herself to contingencies presented by experiences of pain, while Cathy and Bianca have less trouble dealing with such contingencies, Bianca even welcoming them, to some extent, as opportunities to connect with people important to her in her life. This is, arguably a form of “going on”. For Rosenwald, telling and living extend and alternate in time, constituting a causal chain, stories can not only follow events in life, but precede them, which Rosenwald calls “new living action”. The ability to deal with pain in this way, in terms of new openings for living, might make the difference between dealing with pain in a constructive way and experiencing pain in terms of painful, life shattering disruptions, as Jan does. This seems to be closely related to the finding in this study that participants who were able to talk with others about their experiences of pain seemed more comfortable dealing with experiences of pain. Clearly, talking about pain seems to help. In this regard, the female participants seemed to have an advantage over the male participants, at least in daily life. Perhaps we can gain more insight into the forms of talk which help. As the quotes at the beginning of this study suggest, “When my body thinks...all my

flesh has a soul” (Colette, 1907/1980) and “The intending body has a story. A story devoid of meaning for those living it creates a body which is an ‘object body’.” (Cole & Paillard, 1995).

A CONSIDERATION OF METHODOLOGIES

The four methods employed in this research each provided a different perspective on the participants’ experiences of pain. As a result, each method made a valuable contribution to obtaining a multi-faceted, well-rounded view of the research participants’ experience. Acquiring such a well-rounded view was a particular concern in this study, in which the major objective was to investigate people’s own, lived experience in an area which has, previously, been defined in large part by a biomedical discourse, which is, itself, situated in a professional world historically dominated by males. As Renata Klein (1986) puts it, “An emerging postulate for feminist research-is using a variety of methods in order to generate multifaceted information”. Shulamit Reinharz (1992, p.197) adds,

Just as feminist research often draws on multiple disciplines, so too it often draws on multiple, rather than a single, method in a particular project...Feminist descriptions of multimethod research express the commitment to thoroughness, the desire to be open-ended, and to take risks. Multiple methods enable feminist researchers to link past and present, “ data gathering” and action, and individual behavior with social frameworks... Sometimes multiple methods reflect the desire to be responsive to the people studied. By combining methods, feminist researchers are particularly able to illuminate previous unexamined or misunderstood experiences. Multiple methods increase the likelihood of obtaining scientific credibility and research utility.

The experience of using the Narratives Protocol was surprising, for two reasons. First, I found that the Narratives Protocol worked best as a means of helping participants to focus. While the literature on narrative inquiry explains this, with theorists such as Jerome Bruner (1986) pointing out that narrative is “an essential meaning making tool” which helps humans to describe the present, tie present events to past experiences and, thus, project what is likely to occur in the future, I had not anticipated that the Narratives Protocol would function so effectively in helping participants to concentrate and reflect. The effectiveness of the Narratives Protocol in helping participants to direct their attention to seldom discussed experiences of pain became apparent through research participants’ spontaneous comments that writing the two narratives had helped them focus and collect their thoughts.

The other surprising aspect of the Narratives Protocol was that the detailed analyses worked less well in obtaining meaningful data. This was the case largely because the subsequent interview contained so many questions which afforded participants opportunities to explain their own narratives, that additional analytic strategies added very little to the information supplied in the rich commentaries participants supplied about their two written Narratives.

The Map Drawing Protocol was also surprising, but for different reasons. First, in the early phases of developing this method, many people suggested that it wouldn’t work. When I looked back over comments that were made on the Map Drawing, in earlier drafts of the Dissertation Proposal and even farther back in the development of this research, I was impressed by how consistently I was

advised not to use this method. I was often warned that this method would probably not be productive and might not even be feasible. Almost all the comments centered around the concern that most research participants would be made nervous, uncomfortable, perhaps even frightened, by being asked to draw. Many early critics of the research design suggested I try to find some other tool to use for investigation.

These comments proved very valuable in developing this method. I was grateful for the critical discussion which made me aware that research participants might feel uncomfortable at being asked to draw. These comments prepared me to deal with any discomfort or anxiety which might arise. Had I not been prepared for startled reactions from research participants, I might not have been in a position to deal effectively with any uneasiness expressed by research participants at being asked to draw largely due to the fact that, in our culture, adults are not often asked to draw. Indeed, when they were first asked to draw, many participants appeared somewhat nervous and uncomfortable. People frequently warned me that they didn't draw very well, although participants' drawings were always at least adequate and, often, quite beautiful. However, since I had been alerted to possible discomfort, I was prepared to do my best to help make participants more comfortable. I found, in every case, that once participants were told that this was not a test of artistic skill, and that they could just draw what they wanted to draw, all the participants proceeded to draw and, moreover, to become very involved in their drawings. During the early phases of pilot testing, one participant even asked if she could have a copy of her drawing,

explaining that she had enjoyed drawing it so much and was so pleased with her depiction that she wanted to keep it. I made a copy to give her.

A second surprise was that the Map Drawing Protocol turned out to be one of the richest sources of data in the research interviews conducted for this study. Since this was a new method, developed especially to address the research issues being investigated in this project, nobody was entirely sure about what to expect, although pilot testing suggested that it would produce fruitful results. Three aspects of the method seemed to function especially well in this research project. First, drawing the settings in which experiences of pain had occurred provided participants with a context which seemed to help them in reconstructing their experiences. Participants were often able to reconstruct these experiences in a great deal of detail, even though, in some cases, they had occurred a long time ago. Second, this method called upon participants to try to recall experiences of pain at two periods in their lives, when they were ages of six through eleven and ages of twelve through seventeen. These two age ranges were selected because the literatures on Environment and Development suggested that participants' experiences of the environment when they were in these two age ranges were likely to differ. However, the research results showed that a major shift in experiences of pain seemed to occur as participants moved from the first to the second age range, around the ages of eleven to twelve. Again, it appeared that in the age range of six through eleven, participants thought more often of experiences of physical pain. However, when asked to think of an experience of pain in the age range of twelve through seventeen,

many participants who preferred to limit themselves to experiences of physical pain were faced with a dilemma. In this age range, as many participants explained, physical pain is no longer the issue it was when one was younger. As one participant explained, by the age of twelve, people know that they are probably going to be alright when they hurt themselves physically. In the older age range, participants explained that physical pain tends to become more connected to emotional experiences such as shame and embarrassment, to social situations such as school and athletic performance and to issues of gender and identity. This valuable data illustrates the usefulness of this method, which, by asking participants to contextualize their experiences of pain, helps their recall. Finally, asking participants to contextualize their experiences of pain provided valuable information concerning the ways in which they deal with pain, which could aid in developing more comprehensive scales.

The questions based on the life stories literature which were included in the Interview Protocol also proved valuable and constituted an important part of the overall Interview. This section of the Interview appeared to provide participants with an opportunity to pull together their thoughts and reflections on their experiences of pain, and most importantly, to clarify for both themselves and the interviewer, how these experiences figured in their lives in general.

However, I think it will prove useful to others who are considering the use of this method if I mention that I found myself thinking most critically about this method. Although I ultimately concluded that this method formed an essential element of the research design and that I would definitely consider using it again

in similar research, I viewed it the most critically because it was difficult and time consuming. I found the analysis of how individual research participants constructed their experiences of pain over the course of the interview especially time consuming. In addition, each method employed served to make an already long interview longer, which caused me to reflect critically, and repeatedly, on all the methods used. In the case of the questions in the section of the Interview inspired by the literature on Life Stories, both these factors caused me to wonder, on occasion, if the time invested would be justified by the results obtained. Based on my experience in this project, I would say that it is important to ask oneself whether there are enough indications, based on the relevant theoretical literature, that questions about the role a phenomenon plays in the participant's life and a close examination of the way in which individual participants portray their experience over the course of the interview will produce needed, relevant information. In the case of the current research, I concluded that the approach provided invaluable information that could not have been obtained in any other way.

The analysis of the way in which five individual participants depicted their experiences of pain over the course of the interview yielded a very different picture of the participants' constructions of their experiences of pain. It was surprising to discover how different pain looks when viewed from within the person's own, lived, daily experience compared to the view provided by the clinical, biomedical gaze. This analysis was especially helpful in revealing the ways in which participants themselves viewed their experiences of pain and how

they formed connections between their experiences of pain and other aspects of their lives. Most importantly, it revealed that, from the perspective of the person who experiences pain, pain appears to play a central role in the ways people construct their experiences of their bodies, their worlds and their “selves”.

The CSQ, the standardized scale used to appraise the ways in which participants deal with experiences of pain, was initially included to provide a comparison between the ways participants spontaneously described dealing with their experiences of pain and their responses to statements about how they deal with pain on a standardized scale. Once again, the results were surprising. First, participants’ reactions to the scale after having the opportunity to discuss their experiences of pain in depth for over two hours, were interesting because participants offered to explain how they were reading questions and to answer questions with different views of pain in mind. In addition, it was interesting to find that there was a good deal of agreement between the answers participants provided on the CSQ and their spontaneous descriptions, offering one more source of support for the research findings. Finally, divergences in results obtained using more open-ended methods and scaled responses provided useful and interesting data.

Finally, the Interview Protocol itself appeared to work well as an interactive tool which helped participants to investigate their own experiences of pain in their lives. It appeared to help the participants themselves explore and understand the ways in which they construct their experiences of pain and of their bodies, including the roles of unique personal experiences and social and cultural

practices. The Interview also seemed to help participants reflect on the influence these experiences have had on the ways in which they deal with pain. Many participants said that talking about their experiences of pain had helped them both to see how pain affected their lives and to use this knowledge in dealing with pain in the future. In addition, participants' constructions of their experiences of pain appear to be an important factor in their attitudes toward a range of health issues, including treatment seeking and complying with medical advice. This research approach could be helpful in understanding how participants themselves are constructing their experiences of a range of illnesses.

ETHICAL CONCERNS RAISED IN THIS RESEARCH

A key issue is that research participants were asked to select the names they preferred to have used when referring to them in reports on the research. The decision to ask participants to select their own names was made in order to help empower them. During the interview, participants seemed pleased at being asked to select their own names. They displayed a great deal of imagination and inventiveness, often taking the time to explain that the names they selected had always been favorite names or names they wished they had been given at birth. However, their selection of their own names raises a serious ethical concern, since this makes it more likely that they will be able to identify themselves in written reports of the research. It is important to consider the balance of risks and benefits involved in asking participants to select their own names.

Ruthellen Josselson (1996) points out the huge responsibility which a researcher always assumes when she undertakes to write about other people's lives. She explains the heightened level of importance that the act of writing itself confers upon what is written, saying, "Written events gain a substantiality above that carried by memory or speech." Josselson expresses concern about the "fixed" quality of writing, its tendency to sum up and encapsulate. She also stresses that researchers need to pay careful attention to the tendency of the written account to make what has been written appear "true", as though it is incontrovertibly established for all time. The act of writing down a narrative removes the account from the flexibility and ability to re-work narratives and stories which occurs in real life.

Josselson also warns researchers to be concerned about the intrusiveness of the experience of being written about. Unlike the give and take of the verbal exchange which occurs in the interview situation, during which the researcher can be responsive to the research participant, when the researcher writes about the participants, the ongoing interaction is absent. In writing the research, the researcher's position in regard to the participant changes. When writing, the researcher is likely to be using the participants' lives for her own purposes, to make a point and to demonstrate this point to others. Josselson emphasizes that, beyond the intrusive character of the act of writing, the presentation of people's lives as data to support a research point can seem like a betrayal of the research participants. Both these concerns become more urgent

in this study, in which their selection of their own names increases participants' abilities to identify themselves in the written account.

Josselson also points out that, while narrative researchers have begun to explore the ways in which exchanges with participants during the actual interviewing procedure may affect participants' lives, they have paid less attention to the ways in which what we write about their lives may affect participants. Josselson herself admits that her training and long experience as a psychotherapist make her much more comfortable talking with people about their lives. Even when intimate details or painful emotions are revealed during interviews, she trusts that her "ability to understand another person's experience is affirming to him or her."

I was and remain concerned about the participants in this research. The issues Josselson raises are particularly relevant because I asked participants to choose their own pseudonyms. This decision on my part has proven to possess the proverbial "two prongs" offering the possibility of both benefits and dangers. I decided to have participants choose their own names because I thought it would give them a feeling of inclusion and empowerment, which did, indeed, seem to occur. At the end of what was usually a long interview, almost always in excess of two hours, just as we parted, I asked participants if they would please pick a name which I could use when writing the results of the research. The participants always looked pleased. As I mentioned, they seemed to be very involved in the names they picked, frequently choosing to explain to me why they selected these names and what significance these names held for them. Kawika

offered an especially good example of this when he explained that the name “Kawika” is Hawaiian for “David” and is meaningful to him because of Hawaii’s importance to him as a place where he has met many other people who come from ethnic backgrounds similar to his own. For this sense of delight and engagement alone, I would be tempted to ask participants to pick their names, if I were to undertake a research project similar to this one again.

That phrase, “a research project similar to this one” raises an especially important point. I think it is important to discuss the ethical issues involved in writing about the lives of the research participants, not as “generalized” research participants, but as the research participants in a specific study. This is a particular study, with particular issues. It is not, nor is any study an “everystudy”. Josselson raises important ethical concerns, which need to be considered in the context of each study conducted. Thinking about my overall experience working with the participants in this study, I think I would once again ask participants in a similar study to choose their names because of the nature of the research and the kind of involvement between participants and researcher which this study fostered.

This study was unusual in that it asked participants to share their personal, daily life experiences in an area which has been dominated by an expert discourse, the clinical, biomedical discourse. Although I had decided to let participants choose their own names when I designed the research, I would not have continued with this practice if the research participants had not seemed to become so engaged when asked to select their own names. I don’t think

participants would necessarily have been so pleased at being asked to select their own names if this did not seem consistent with the overall approach used in the research. Participants' engagement in choosing their own names seemed to be connected to the overall tone of the research being conducted, in which they seemed to become interested and which seemed to foster engagement and exploration. If this were a research project in which the investigator started with a clear hypothesis, to be tested and proven or disproven, I think participants would have found it inconsistent and illogical to be asked to choose their own names. However, this study was very much a mutual exploration. Both participants and researcher were equally involved in finding out about a subject infrequently discussed in our culture and so thoroughly dominated by the expert discourse of biomedical practice that its role in people's everyday lives has become obscured.

Because of the nature of this study, I would ask participants in a similarly constructed study about an under-investigated subject to pick their own names, knowing that it would make what I wrote about them more accessible to them. Although I agree with Ruthellen Josselson that the written word tends to take on the immutable quality of eternal truth, this report aims at opening the door to further discussion rather than at making an eternal statement about the nature of pain. I would like my research participants to feel that they are present in the discussion offered in this document, that their voices are being heard, and that they can draw upon any findings of interest to further explore their own experiences. Josselson agrees that, although doing narrative research is an

ethically complex undertaking, we should not stop doing it. It is important work but “work we must do in anguish”. She cautions that the work of exploring people’s lives to make them examples of principles or concepts or to support a theory, will always be intrusive and unsettling for the person who encounters his or her description in such a text. She admonishes us not to stop worrying, not to stop suffering over the possible disjunctions which occur when we try to tell another person’s story. She advises us that it is our discomforts in doing this work that will protect we ourselves and the research participants with whom we work from going too far. She offers hope that deep concern and constant vigilance will make us careful compatriots in our explorations.

Chapter Eight

IMPLICATIONS AND SUGGESTIONS FOR FURTHER RESEARCH

IMPLICATIONS

The implications of this research fall into five major groups. First, there are implications for clinical practice, including suggestions for clinical practice in health care settings, for the training and education of physicians and other health care professionals and for the development and practice of narrative medicine. Second, the study offers ideas for improvements in health care treatment for women, men and adolescents, in particular. Third, the study suggests ways to modify and improve standardized scales used in assessing pain. Fourth, this research makes a contribution to the development of a biopsychosocio-cultural model of human health and illness. Finally, there are policy implications which might help address the recent controversy surrounding the cox-2 inhibitors, such as Vioxx and Celebrex, popular medications for pain which were removed from the market in Fall, 2004.

Implications for clinical practice in health care settings

What are the implications of this research for medical practice in health care settings? There are several. When I began this research, I was a proponent of a model of pain which would help practitioners deal with the patient's lived experience of pain. Recent research on pain has made it increasingly clear that, in order to help people in pain, it is important to

understand their experiences of pain. However, I was also troubled about how feasible such a model would be in actual clinical practice. If each individual has her or his own, individual experience of pain, how can medical practitioners be expected to deal with such diversity in the hectic milieu of the contemporary clinical setting? Yet, in the year 2000, physicians were mandated to deal with their patients' pain adequately and effectively. How can all of this be accomplished? The real life demands of clinical practice seem to be inconsistent with the demands of a model which involves taking each patient's lived experience into account. This research presents several possibilities.

First, a shortened version of the Interview Protocol might be of use in clinical work with both pain patients and patients experiencing pain related to medical treatment or to other disorders. A short version of the Interview Protocol, which maintains its interactive format, might provide patients with a tool to explore their own experiences of pain. Such an interactive interview could be useful in helping both patients and health care professionals understand more about how each patient deals with pain and what approach to pain management might prove most useful to that person. Participants in this study often commented on insights they obtained into their own ways of dealing with pain, where these ways of dealing with pain originated in their lives and how it might be possible to both view and deal with pain differently. This suggests that an interactive interview could help patients to gain insight into their own ways of dealing with pain and to become more involved in their own care, promoting a more collaborative relationship between physician and patient in managing pain.

Findings in this study also suggest specific areas of patients' experience with pain to which attention should be devoted in health care settings. First, this research suggests that the way in which participants' families dealt with pain when they were growing up has a lasting influence on the ways in which individuals themselves deal with pain as adults. In standard medical protocols, patients should be asked about family patterns of dealing with pain.

Second, participants reported that their constructions of pain changed when they entered the age range of twelve through seventeen. Participants described themselves as becoming more concerned with mental and emotional forms of pain when they entered this age range. They also described how their experiences of pain became increasingly linked to the social and cultural worlds in which they lived, including their perceptions of gender roles. This suggests that medical protocols should investigate experiences in this age range when interviewing people about pain.

Implications for the training and education of physicians and other health care professionals

This study suggests that learning to listen to the patient's description of her or his lived experience of pain should be an important part of the education and training of physicians. A major finding in this study was that people who had parents and caretakers who not only "fixed it" when they injured themselves, but who also talked with them about their experiences of pain, seemed to find pain easier to deal with as adults. Even participants, such as Jack, who had not been

able to talk with others about experiences of pain when they were children, explained how helpful they found opportunities to share their experiences with others as adults. The results of this study suggest that the education of physicians should include learning to listen and respond to the patient's accounts of experiences of pain, with sympathy, sensitivity and compassion.

While the introduction of sophisticated technological interventions has served to greatly enhance people's health, the expanded presence of technology in medical care has also introduced increasing distance into the relationship between physician and patient (Reiser, 1978). While the patient's account of her or his experience and suffering was once a central component of the physician's consideration of the patient's condition and treatment, the increasing importance of technology in the clinical encounter has made the relationship between patient and physician less personal. The patient's own account of her or his life and the way the illness has impinged upon it have come to be regarded as less relevant to effective diagnosis and treatment (Reiser, 1978). However, based on the findings in this study, it appears that pain is an area of medical practice in which the lived experience of the patient plays an especially crucial role. The study suggests that for medical practitioners to help patients deal effectively with pain, it is important they learn to listen to, understand and acknowledge the patient's values and meanings concerning pain and how these values and meanings relate to the patient's life. Physicians, whose training has, historically, educated them to conduct interviews in which they guide patients' responses to focus on the physiological aspects of their illnesses, must be helped to learn how to elicit

and pay attention to patients' accounts of the role their experiences of pain play in their lives.

Implications for the development and practice of narrative medicine

The recent interest in Narrative Medicine could help in developing clinical approaches which would help both patients themselves and medical practitioners explore and understand the many dimensions of patients' experiences of pain. Since people's experiences of pain seem to play a central role in their constructions of their bodies, their "selves" and their worlds, narrative and life story explorations of pain in medical settings could help to provide a better understanding of how the patient and her relatives and friends understand and situate the patient's pain in the context of the patient's overall life. Such an approach might also provide a new view of pain patients, not as somatizing or "problem" patients, but as people with goals, plans and ambitions, people with lives to live, for whom the construction of their bodies plays a significant role in their lives and interpersonal relations.

Implications for women's, men's and adolescents' health

The results of this study highlight how strongly the biomedical model is influenced by male values. Indeed, the biomedical model has been criticized as a model of human health and illness which is based largely on male values in a specific historical period. Katz-Rothman (1982) points out that, in the biomedical model, the male body is regarded as the norm. This has created difficulties for

the effective medical treatment of women (Katz-Rothman, 1982). For example, in biomedicine, experiences normal to female life, such as menstruation, birth and menopause are often pathologized. In addition, “female” complaints, such as distress associated with menstruation, childbearing and gynecological conditions, have often been disregarded, minimized or “naturalized”, explained away as inevitable concomitants of women’s physiologically determined destiny as childbearers. In this study, women reported that their complaints regarding menstrual pain were often disregarded or minimized by medical practitioners. In addition, women sometimes reported that, because medical practitioners regarded pain related to menstruation as a “natural” part of being a woman, these practitioners expressed impatience with the women’s concerns about menstrual pain. Several female participants explained that they felt hurt and angry at being told that their pain was simply a normal part of being a woman, which they just had to accept.

Several female participants also talked about their hurt and anger at being told that the only way to treat their sometimes severe and life altering menstrual cramps was to take birth control pills. They reported that, when they explained to physicians that the side effects associated with taking these pills only made the situation worse, they were told that birth control pills are the only treatment and, again, that experiencing this kind of pain is just part of being a woman. Women in this study reported that their distress at such side effects as bloating and weight gain was ignored by physicians. However, in the story Sooty told, for example, it is clear that her concerns over weight gain are not inconsequential or frivolous in

the context of her life as she experiences it. Sooty explained that she was under strong pressure to enter into a marriage arranged by her family, while she herself preferred to meet a man, possibly not from the same cultural background as herself, whom she personally wanted to marry. However, Sooty also explained that she has a tendency to gain weight, which she feels is exacerbated by taking birth control pills. This, in her view, presents a problem, making her feel less attractive and, thus, less likely to be able to attract a desirable husband without her family's assistance. Thus, Sooty views the side effects of birth control pills as an additional obstacle to resolving this key, and very distressing, issue in her life.

Important gender differences in the construction of pain emerged in this study. Gender differences in dealing with pain should be considered and explored as a standard part of patient interviewing and treatment. Women in this study consistently said that talking to others about their experiences of pain is important to them in dealing with their pain. Moreover, female participants were more willing than male participants to explore the emotional aspects of their experiences of pain and more comfortable dealing with the emotional aspects of their experiences of pain than men. However, part of the male bias of biomedicine is the high value it places on a discourse which emphasizes unemotional and "objective" descriptions of health conditions. Along with discounting women's reports of pain associated with "female complaints" as "natural", the biomedical emphasis on male values leads to a focus on observable physical phenomena and a devaluation of emotional experience. This can contribute to a view of women's ways of talking about their experiences

of pain as “hysterical” and exaggerated. As a result, women’s need to talk about their experiences of pain and desire to be able to express their emotions concerning painful experiences is often discredited in medical settings. Female participants’ reports of not being listened to or being accused of exaggerating and “making things up” may be connected to their different ways of constructing experiences of pain. While women value talking about their experiences and expressing their emotions, medical practitioners are trained to disregard and discredit such accounts. In addition, practitioners trained in a biomedical model dominated by male values may not feel comfortable dealing with these forms of expression. This may result in reports made by female participants that they felt they were not being listened to, that medical practitioners acted as though they were just making things up or exaggerating.

Female participants’s constructions of their experiences of certain kinds of pain, particularly chest pain, differed from men’s. Attention to such gender-related differences in construction could help to improve the treatment of women’s pain and of other medical conditions experienced by female patients. For example, a major concern in Women’s Health is the undertreatment of women’s pain (New York Times, Sunday, July 22, 2003). Clearly, if medical practitioners discount female patients’ different ways of constructing their experiences of pain along with regarding their expressions of distress as exaggerations, this will contribute to the disregard for and undertreatment of women’s pain.

Finally, the women in this study reported feeling that they were responsible for their pain and, thus, felt that they were not entitled to seek help or relief. It seems likely that women's encounters with medical care in which their experiences and accounts are discredited contribute to their feelings that they are responsible for their own pain and that they do not have the right to ask for help.

On the other hand, male participants in this study explained that they were not comfortable talking about their pain. The results of this study indicate that participants who reported being able to deal with pain comfortably as adults often also reported that their caretakers listened to and talked to them about their experiences of pain as they were growing up, rather than just "fixing it." Thus, it is likely that male patients could be aided in dealing more effectively with their pain and its possible relation to other medical conditions, if they were gently and carefully helped and encouraged to talk about their experiences of pain.

Several male participants also talked about a "syndrome" in which they appeared to form intricate interconnections between their experiences of pain and senses of self. Male participants often talked about their need to view themselves as physically active and effective, a construction of self which they frequently tied to their abilities to play sports. Careful attention should be devoted to this "syndrome" and its connections to men's senses of self and identity in caring for male patients who experience pain. Male participants often talked about ignoring pain and continuing to be active in the face of serious injuries in order to maintain their senses of self. Attention to the male propensity

to remain physically active in the face of pain and their discomfort in talking about pain might help in preventing male patients, in particular, from ignoring serious conditions and delaying needed treatment.

The results of this study show that participants reported a change in the way they constructed their experiences of pain which occurred within the age range of twelve through seventeen. They reported that they became more concerned with mental and emotional forms of pain when they entered this age range. They also described how their experiences of pain became increasingly linked to their social and cultural milieus, at this age, and more connected to their perceptions of gender roles. As Brooks-Gunn and Graber (1999) point out, adolescence is often viewed as a unique period in contemporary lives because, during this period, change is occurring in many areas of life. Among these changes is the development of a mature body, capable of reproduction. Biological maturity in humans is gender-specific, with the result that psychological changes which accompany these physiological changes are gendered and relate to gender identity (Ashmore, 1990; Hudson, 1983). The results of this study indicate that experiences of pain are important in the development of sense of self. Moreover, during this period, as the research participants mentioned, changes in several key relationships occur, particularly in the adolescent's relationships with parents and peers. Brooks-Gunn and Graber (1999) take the position that the physical changes which occur during these years and their meaning to the individual, peers, parents and authority figures, such as teachers, become incorporated into the growing person's identity. The

results of this study indicate that experiences of pain constitute key moments during adolescence in which these meanings are negotiated and incorporated. Thus, in caring for teenaged patients who experience pain, special attention should be devoted to helping them to understand and deal with both the experience of pain itself and its effects on their senses of self, constructions of gender and relations with others.

Implications for improved scale construction

This study suggests that current scales for assessing pain do not sufficiently address the richness of experience and the many voices which contribute to participants' constructions of their experiences of pain. Family members, friends, peers and authority figures all appear to play roles in participants' constructions. This is illustrated most clearly by the stories participants told while drawing their two Maps. Scales could be made more effective by offering participants opportunities to contextualize their experiences, helping to capture the richness of their constructions. Bertha's comments that she found statements on the scale ambiguous because they did not specify the circumstances in which the pain occurred, help to illustrate the need for greater contextualization. One approach could be to present brief scenarios along with simple statements on questionnaires designed to investigate ways of coping. As Morris, (1991) points out, the experience of pain is time and place specific. Pain is not simply a physiologically based, universal phenomenon.

Participants' spontaneous explanations of how they dealt with pain also revealed that specific stances toward pain were often colored by nuances which made a significant difference in what the participant was saying about how she or he dealt with pain. For example, Olivia portrayed the way she deals with pain by saying, "Don't fuss. Keep going.", consistent with her tendency to endorse statements on the CSQ in the category of Coping Self Statements. However, she went on to say, "I feel I have to deny my emotions. If you don't, you're not strong. You're weak". The second part of her statement indicates a discomfort, even some conflict, with the stance characterized by the statements in the Coping Self Statements category.

In addition, the scale used, the CSQ, did not provide opportunities for participants to talk about their use of talking with others as a form of social support in dealing with pain. The scale only offers one statement which could be viewed as including talking with others, "I try to be around other people". However, this statement is scored in the category of Increased Behavioral Activity. When Cathy said, "I can face it-not cry in front of people.", her statement appeared to be consonant with her endorsement of Coping Self Statements". However, she also said, "I talk to people who tell me how to handle it and get information." In this case, she was not talking to people in order to distract herself from her pain, but as part of an active coping strategy. A more multi-dimensional scale construction, including questions on dimensions dealing with emotions and social support might help to elucidate these different aspects of participants' ways of dealing with pain. It is also important to note that the

omission of these dimensions from the scale appears to be consistent with a masculine orientation toward pain, in which the roles of emotions and talking with others for social support are de-emphasized. Bob's comments on the scale, when he offered to fill out the scale in two different ways, with his old view of pain as strictly physical and his "new view" of pain as incorporating both physical and emotional experiences of pain, serve to illustrate this point. The inclusion of more items which deal with women's ways of constructing their experiences of pain could help to make standardized scales more sensitive to women's ways of constructing and dealing with pain.

Finally, as Sergei illustrated when he asked if he could fill out the scale one way for dealing with physical pain and another for dealing with emotional pain, even though participants were not able to maintain a consistent bifurcation between physical and emotional pain, both male and female participants did sometimes make distinctions between the ways they dealt with physical and emotional pain, respectively. If people deal differently with emotional and physical pain, it would be useful to have scales which could help us in evaluating these differences.

Implications for the development of a biopsychosocio-cultural model of human health and illness and for the treatment of other illnesses

I began this research with the aim of investigating pain from a biopsychosocio-cultural perspective because I thought this investigation would provide information on how such a model could help in addressing other

illnesses, such as the classic psychosomatic disorders and substance abuse disorders, as well as pain. I expected to find that what I discovered about the role of psychological, social and cultural factors in regard to gender and pain would translate directly into a model which would apply to these other disorders. Now, I think this study could contribute to the study and treatment of other disorders in two ways. First, I think this type of interview, which draws on narrative construction and map drawing, could help in investigating participants' situated, lived experience in regard to illnesses and disorders such as the classic psychosomatic disorders and substance abuse. The ways in which people construct their selves and their worlds, based on social relations, practices and discourses which take place in real places could offer useful ways to study constructions of self, world, and body in other disorders. In addition, I think it could prove helpful to select age ranges of theoretical interest, to begin with, perhaps, those used in the Map Drawing Protocol in this study, to help in identifying ages at which participants' experience might undergo important changes. In other disorders, participants themselves might be asked to try to identify points in their lives where they perceive change occurring.

Second, it appears that people's constructions of their experiences of pain function as a nodal point in their constructions of their selves, their bodies and their worlds. This key construction may provide clues to how an individual relates to her or his body, which, in turn, may help in understanding how people deal with other illnesses. A brief anecdote may help to illustrate this point.

While I was conducting this study, I had a conversation with a male friend who had just wrenched his back. As a result, he was in a considerable amount of pain. As we talked, he asked me if he wasn't right in recalling that my dissertation work had something to do with pain. I replied that it did, but I didn't know if I had discovered anything that would be useful to him in his current predicament. However, I told him one strong finding had been that research participants reported that the way in which their families dealt with pain when they were children had influenced the ways in which they deal with pain as adults.

Much to my surprise, especially since he was in severe pain, my friend burst out laughing. When he recovered his composure, he explained that he was laughing because he thought what I had just suggested was very true, in his case. He said that he thought that the ways in which he deals with pain, and his attitude toward pain, are very much connected to the ways in which his family dealt with pain while he was growing up. He explained that his attitude toward his body was, "You're not going to get me down. It's you or me, and it's not going to be me". He seemed to be describing a sort of adversarial relation between his mind and his body, in which his "mind" was going to triumph over "matter" in the form of his body, in what might be called a Cartesian construction.

He explained further that, when he realized that he had thrown his back out while lifting a very heavy sack, in itself, perhaps, not a wise idea, he found that his back hurt, badly. He took this attitude toward this pain, and, based on this perspective, went immediately to the gym, where he engaged in a strenuous

workout. While my friend did not mention this possibility, since I was aware of the results of this study, I could not help thinking that gender differences in the construction of experiences of pain, particularly the “syndrome” mentioned by male participants, seemed to be pertinent to this decision on his part. Following this self-prescribed course of action, he discovered that his back hurt him much more than it had before, in fact, that he was now in serious pain. It was at this point that he decided he had better seek medical treatment and called his doctor. When I asked him whether he had explained what he did to the doctor, he replied, “Of course not. He would have scolded me!”. This example also serves to add force to my suggestions that attention to gender differences in the construction of experiences of pain can be useful in improving health treatment.

Constructions of the meaning of pain such as those portrayed in this example might have a profound effect on the ways in which people deal with both their experiences of pain and with other bodily experiences. People’s constructions of pain may underlie or play a role in treatment seeking, compliance with medical advice, and ways of regarding and dealing with other experiences of illness. Moreover, in this study, it appeared that pain was connected to or constituted a component of many other types of illness experience, including depression, alcoholism and sexual abuse. Research participants connected these experiences to an overall experience of pain.

Implications for Policy

In the Fall of 2004, while I was in the midst of writing the results of this study, Merck Pharmaceuticals withdrew their popular pain medication, Vioxx, from the market because research indicated that prolonged use of Vioxx, one of the cox-2 inhibitors, was associated with increased risk of heart attacks. Merck still faces law suits contending that they were aware of these dangers for some time, but were willing to suppress this information, potentially endangering the health of the people who used the product, in pursuit of financial gain. However, subsequently, the manufacturers of other cox-2 pain medications, including Celebrex, decided to allow their products to remain on the market.

During the Winter of 2005, Merck announced that it was planning to re-introduce Vioxx because doctors reported a great demand. Apparently, many patients were still asking for this medication because they were finding that other medications did not provide the relief from pain they had experienced with Vioxx. Doctors reported that patients said that they were willing to take the risks which seemed to be attendant on taking Vioxx in order to maintain the levels of pain relief and functioning which Vioxx had made possible for them.

Situations such as this make it important to understand the role that pain plays in patients' lives. In order to assess the balance of risks and benefits for different patients and to help these patients make the best decisions for themselves, it is necessary to find a way to study the ways patients construct their experiences of pain, including the role pain plays in the patient's life and the meanings pain has for the patient. The need for more sophisticated ways of

studying how pain figures in people's lives is only likely to increase as the population ages and as chronic diseases, some of which involve pain, increase due to longer life spans and improved medical treatment of acute diseases. Such studies can contribute to more effective policies for government approval of drugs for pain relief.

SUGGESTIONS FOR FURTHER RESEARCH

I have three major suggestions to make regarding further research suggested by this study. First, this study investigated the experiences of a relatively small number of participants. In order to assure the validity of these results, subsequent studies should be conducted with larger numbers of research participants. Conversely, this intense, in-depth approach has produced interesting and rich results. This suggests the need for more small, in-depth studies in the future. Second, further studies should be conducted to explore issues raised in this study in more depth, including the role of the family in transmitting ways of dealing with pain and how people's experience of pain changes over the life span. Finally, further studies should explore a model of human health and illness which integrates mind, body, culture and society.

The limitations of this study should be addressed in future research

The limitations of this study should be addressed in subsequent research. This was an exploratory study. There was little previous research on the topic of pain using this approach. As a result, it seemed necessary to conduct lengthy,

in-depth interviews in order to thoroughly investigate as many aspects as possible of the research participants' experiences of pain in the course of daily life. The use of such a lengthy and detailed Interview Protocol meant that a relatively small number of participants could be interviewed. The findings of this study should be confirmed using studies with greater precision, including larger numbers of participants and groups of participants from different ethnic and educational backgrounds.

On the other hand, this small, intensive study produced interesting results. Intensive studies with similar or even smaller numbers of participants might be useful in further elucidating the complex phenomenon of human pain. Further in-depth study of the human experience of pain, including intensive investigation of some of the areas suggested by the results of this study, could be useful.

Further research should be undertaken to study the role of family ways of dealing with pain and how these ways of dealing with pain are transmitted in families

In this study, participants reported that the ways in which family members dealt with pain when they were growing up affected the ways they deal with pain as adults. However, the data do not clarify how these ways of dealing with pain are transmitted in families. Participants' comments suggest that modeling, family storytelling or the pattern of interaction between child and parent are all possibilities. Moreover, these different means may all play a role in family transmission of ways of dealing with pain and, perhaps, interact with each other

in interesting ways. Further study is necessary to investigate how ways of dealing with pain are transmitted in families. In addition, such studies could yield important information about communications about pain, in general, which could prove useful in clinical interventions.

In addition, some participants portrayed situations in which family members, particularly parents, had different ways of dealing with pain. Further study should be devoted to how these different ways of dealing with pain are dealt with by the children in the family and the effect they have on the ways in which the child deals with pain as an adult. The roles of mothers and fathers in shaping the child's ways of dealing with pain should be addressed in further studies. In this study, there was too little data to draw any conclusions, but both female and male participants commented that it was difficult to ascertain what their fathers did to deal with pain. Participants said that fathers are less likely to reveal that they are experiencing pain, making their ways of dealing with pain more difficult to ascertain, since pain in another can be deduced only through verbal reports and observations of behavior.

Further research should investigate people's constructions of pain over the course of life, to develop a Life Span Developmental view of people's constructions of pain.

One especially intriguing finding of this study was that participants' depictions for their second Maps suggest that there is a change in most participants' experience of pain which occurs somewhere around the transition to

puberty. This suggests that there might be changes in people's constructions of their experiences of pain at other ages and that these changes could come at different ages in different cultures. A cross-cultural, Life Span Developmental view of the ways in which people construct their experiences of pain could be helpful in understanding and treating pain in people as they progress through the life span.

Conversely, some ways of dealing with pain may persist over the life course. Some gender differences in the construction of pain revealed by the results of this study may continue into older age, but may appear somewhat different to the outside observer due to changes in the social and cultural milieu in which the person lives. Two brief anecdotes will illustrate this point.

Over the past year, while I was analyzing the data from this study, two friends told me stories about older relatives which, on reflection, seemed to be related to each other and to the results obtained in this study of younger adults, aged eighteen through fifty. The first story involved the friend's mother. He expressed concern for her, saying that she had begun to focus a great deal on her experiences of pain. This surprised him, since she had always been able to "soldier through", remaining very active in spite of any pain she experienced and rarely talking about her pain. My friend mentioned that his father, with whom his mother had lived for many years, had died a few months previously. In addition, several of his mother's close friends had also died recently, while others had moved away.

I don't know if I would have realized the possible connection with my own research if another friend had not told me a somewhat similar story a few weeks later. This second, female, friend told me about two cousins of hers, a brother and sister, who are fairly close in age. Similar to my first friend's story, she told me that, according to what she had been told by her male cousin, her female cousin had recently begun to pay much more attention to her experiences of pain, talking about her pain and becoming much less physically active.

According to my informant, her brother found this especially surprising since his sister has experienced rather severe pain for many years, but had remained active and had rarely talked about her pain. The brother contrasted this focus on pain and inactivity with his own way of dealing with pain, which was to remain very active in sports which he enjoyed. He told my friend, his cousin, that he was very surprised at his sister's recent behavior, since she, too, had always been an active person who enjoyed sports and physical activity.

It occurred to me that these three older people, two women and one man, were dealing with their experiences of pain, and, possibly, constructing their experiences of pain, in ways which were very similar to those of the female and male participants in this study. In this research, women reported that talking to others is important to them in dealing with pain. Men reported that being physically active and involved in sports but not having to talk to others about their experiences of pain is important to them. It seems possible that the two women my friends told me about were no longer able to talk to important people in their lives, people on whom they may have relied to talk about pain, because these

friends had moved away or died. On the other hand, the man my friend told me about was able to continue to engage in the athletic activities which he had enjoyed all his life and which may constitute an important way of dealing with pain for him. Even though my friends described both women as active people, being physically active and engaged in sports may not play the same role in their constructions of their experiences of pain and ways of dealing with pain as in the man's. Research on consistencies and changes in the ways women and men construct their experiences of pain at different ages and the ways these constructions affect coping with pain could help in understanding and treating people of different ages who experience pain.

**Further research should be undertaken to develop a model which
integrates mind, body and environment**

This project might be viewed as a contribution to a model which is an alternative to the dualistic, Cartesian biomedical model. Such a model might be of particular help in dealing with pain and other illnesses such as the chronic illnesses and the so-called psychosomatic disorders. Further research should be undertaken to investigate a more integrated model.

Moreover, the role of the environment in women and men's constructions of their embodied selves deserves more attention. It was surprising to learn that participants, like Cathy and Sergei, had places in which to play as children where they felt free to do whatever they liked, but where their caregivers were able to watch over them with ease, which seemed to contribute to greater comfort in

dealing with experiences of pain. However, participants like Olivia, Bertha and Finn, who grew up on the east coast of the United States, described playing in dangerous places, such as parking lots and yards paved entirely in concrete, making it difficult for caregivers to watch over them and likely that they would injure themselves. Moreover, Olivia came to accept a personal attribution that she is “clumsy” as a means of accounting for her frequent injuries while playing in her caretaker’s paved yard as a child.

The women and men in this study portrayed very different experiences of their environments. Elizabeth Grosz (1995) views bodies as formed by the city spaces they inhabit, in a productive model in which bodies and cities mutually define each other. She suggests that we consider the relationship of spatiality, space and the design professions, such as architecture and urban planning, to subjectivity, corporeality and thought when designing places for our future, taking into account the invaded nature, for women, of both spaces and bodies.

APPENDIX A The Interview Protocol:

PART ONE: BACKGROUND INFORMATION (SECTION A)

First, I'd like to ask you a few background questions about yourself.

A1) Note person' gender. M F

A2) Which of the following categories best fits your age? 1) 18-23 2) 24-29
3) 30-35 4) 36-41 5) 42-46

(also, if possible, get exact age).

A3) What is your ethnicity? (What do you identify as your ethnicity?) (This will be the participants' own self identification, phrased in the participants' own words, i.e., if they self identify as "Carribean" rather than "African-American", the choice of "Carribean" will be used for research purposes).

A4) What is your marital status? 1) single 2) married 3) separated or divorced 4) have a partner, but live alone 5) live with a partner

A5) Do you have any children? Probe: Your own? Through marriage (i.e. stepchildren)? Adopted or through foster care? Adult (over 18)? Younger than 18?

A6) What was your overall household income last year? I'll read you some categories. Please stop me when I get to the one that best fits your total household income last year.

1) under \$10,100 2) \$10,1000 to 20,000 3) \$21,000 to \$30,000 4) \$31,000 to \$40,000 5) \$41,000 to \$50,000 6) \$51,000 to \$60,000 7) \$61,000 to \$80,000 8) \$81,000 to \$100,000 9) over \$100,000.

A7) Are you employed? Yes No

A8) What sort of work do you do?

A9) What was the highest grade of school which you completed?

A10) Do you have health insurance? Yes No

A11) What type of health insurance, do you have?

A12) Through what auspices do you obtain your health insurance, (i.e., self paid, through employer, through union, through government, as in medicaid, medicare, SSI, disability insurance) ?.

A13) Do you use any alternative sources of health care, (i.e. herbalists, botanicas, acupuncture, massage, chiroprator etc.) and, if so, which ones?

A14) What medications do you take? Do you take any medication (s) specifically for dealing with pain?

A15) How do you obtain these medications (i.e.prescriptions, over the counter, private sources, etc.)?

PART TWO: THE PAIN NARRATIVES PROTOCOL (SECTION B)

Now that I know something about your background, I would like to talk with you about experiences of pain which you have had in your life. I would like to ask you about some times in your everyday life when you experienced pain. It can be any kind of pain.

(The following protocol will be used to construct a list of experiences of pain in the participant's life. The researcher will ask the participant to use this list to select first one experience, then a second experience, which the participant will be asked to write about for about ten minutes. Thus, two narratives will be

obtained from each participant, concerning two experiences of pain, each selected from the co-constructed list.).

Question B1: Can you tell me about some experiences of pain you have had? Based on the answers to this question, the participant and researcher will construct a written list of experiences of pain in the life of the participant.

Question B2: Could you please pick one of these experiences and just take about 10 minutes to write about one of these experiences?

Question B3: Could you please pick another experience and take about 10 minutes to write about it?

Question B4: a) Why did you choose this (the first) experience of pain to write about?

B4b) Why did you choose this (the second) experience of pain to write about?

Question B5 “Let’s just read through this together to make sure I can read it.”

(The participant and researcher will then go over each narrative to make sure the researcher can read the narrative. Any words or phrases the researcher cannot read, she will print in above the written text.

The researcher will ask questions (probe) to clarify that her understanding of the information already provided in the narrative is correct.

The researcher will also try to gain insights into the experience of pain constructed in the written narrative. The researcher will ask the participant to elaborate on the narrative, trying to gain information about the people whose opinions and views were instrumental in developing these ideas about pain, to support an analysis of the “voices” of past discourses in past experiences which can still be heard in the participant’s current narratives.)

(Probe for each experience of pain, if the information is not already provided. If the information is provided, the researcher will merely state her understanding of what has been written to make sure that she understands correctly, citing the words or phrases in the narrative which make her think this.)

Probe 1: Where did it occur? (N1B5a)

Probe 2: When in your life did it occur? (N1B5b)

Probe 3: (*If different*) What age were you? (N1 B5c)

Probe 4: Why do you think you did this? Or didn't do anything? Or didn't do something participant has mentioned thinking of doing, which she or he did not do. (referring to action taken, or not taken, in regard to pain)? (N1B5d)

Probe 5: Why do you think you felt this way about this experience? (Or, if participant didn't mention how they felt: How did this make you feel?) (N1B5e)

Probe B6: Did anyone you can think of in your life tend to do this when they experienced pain?

REPEAT ALL PROBES, as necessary, for Narrative #2:

Probe 1: Where did it occur? (N2B5a)

Probe 2: When in your life did it occur? (N2B5b)

Probe 3: (*If different*) What age were you? (N2B5c)

Probe 4: Why do you think you did this? Or didn't do anything? Or didn't do something participant has mentioned thinking of doing, which she or he did not do. (referring to action taken, or not taken, in regard to pain)? (N2B5d)

Probe 5: Why do you think you felt this way about this experience? (Or, if participant didn't mention how they felt: How did this make you feel?) (N2B5e)

Probe B6: Did anyone you can think of in your life tend to do this when they experienced pain? (N2B5f)

ADDITIONAL COMMENTS AND NOTES TO THIS POINT:

PART THREE: MAP DRAWING PROTOCOL (SECTION C)

MAP 1: Now I'd like you to try to think of an experience of pain in your childhood, from the ages of six through eleven. I'd like you to draw the setting in which this experience occurred. Here is a pad of paper with fairly large sheets of drawing paper in it- and some pencils. Some of them are colored. This isn't an art test. If you feel comfortable drawing things and people, you can, but you can indicate the setting and items in the setting in any way you like.

(Only if necessary, " You don't have to draw pictures, you can draw symbols or indicate things in any way that you're comfortable with.)

(If participant asks what he or she should draw: "It's your drawing. You can put whatever you like in it.)

We can talk as you draw, if you like, or we can talk about what you have drawn later. (Use the following Probes only if necessary)

Probe 1: Try to think of what was going on at the time you had this experience. Can you show me? Can you tell me about it, please? (M1C1)

Probe 2: What was the place like? (M1C2)

Probe 3: Who was there? (M1C3)

Probe 4: What did they say? (record for each person mentioned) (M1C4)

Probe 5: What did they do? (record for each person mentioned) (M1C5)

Probe 6: Were any other places involved? If so, what places? Where were they? (M1C6)

Probe 7: Can you explain why this happened? (M1C7)

Probe 8: Did this experience matter to you? Was it significant in your life? (M1C8)

Probe 9: I notice in your stories that you mention that you are in place. Is this a place where you have found in your life that you are likely to experience pain? (probe for each instance mentioned in stories and maps) (M1C9)

Probe 10: I see in your stories that you mention that you were doing..... Do you think that this is an activity that you are used to having associated with pain? (probe for each instance mentioned in stories and maps) (M1C10)

Probe 11: I notice in your stories you mention that (names of people or types of people) were present. Can you tell me who these people were? Can you tell me what relationship they had to you? (M1C11)

Probe 12: Are these the people (the types of people) who were usually present when such things occurred in your life? (M1C12)

Probe 13: Was this a place where you were likely to experience pain? (M1C13)

Probe 14: Do you think this could have happened anywhere else? (M1C14)

Map 2: Now I'd like you to try to think of an experience of pain in your adolescence, from the ages of twelve through seventeen. I'd like you to draw the setting in which this experience occurred. Here is a pad of paper with fairly large sheets of drawing paper in it- and some pencils, some of them are colored.

Do you have any questions? It's like last time, only a different age.

(Only if necessary: This isn't an art test. If you feel comfortable drawing things and people, you can, but you can indicate items in the setting in any way you like.)

(Only if necessary, " You don't have to draw pictures, you can draw symbols or indicate things in any way that you're comfortable with.)

(If participant asks what he or she should draw: "It's your drawing. You can put whatever you like in it.)

Just like last time, we can talk as you draw, if you like-or we can talk about what you have drawn later.

Probe 1: Try to think of what was going on at the time you had this experience. Can you show me? Can you tell me about it, please? (M2C1)

Probe 2: What was the place like? (M2C2)

Probe 3: Who was there? (M2C3)

Probe 4: What did they say? (record for each person mentioned) (M2C4)

Probe 5: What did they do? (record for each person mentioned)
(M2C5)

Probe 6: Were any other places involved? If so, what places? Where were they? (M2C6)

Probe 7: Can you explain why this happened? (M2C7)

Probe 8: Did this experience matter to you? Was it significant in your life? (M2C8)

Probe 9: I notice in your stories that you mention that you are in place. Is this a place where you have found in your life that you are likely to experience pain? (probe for each instance mentioned in stories and maps) (M2C9)

Probe 10: I see in your stories that you mention that you were doing..... Do you think that this is an activity that you are used to having associated with pain? (probe for each instance mentioned in stories and maps) (M2C10)

Probe 11: I notice in your stories you mention that (names of people or types of people) were present. Can you tell me who these people were? Can you tell me what relationship they had to you? (M2C11)

Probe 12: Are these the people (the types of people) who were usually present when such things occurred in your life? (M2C12)

Probe 13: Was this a place where you were likely to experience pain? (M2C13)

Probe 14: Do you think this could have happened anywhere else? (M2C14)

PART FOUR: WAYS OF DEALING WITH PAIN IN EVERYDAY LIFE (SECTION D)

BEGINS WITH LARGE, OPEN-ENDED QUESTION

**A. Now, I'd like you to think about experiences of pain you've had
THROUGHOUT YOUR LIFE. You've told me about four specific
experiences and you've explained how and why you selected them, what**

was going on at the time, who was there and what they did, how they figured in your life. Now, I'd like you to try to draw on that previous discussion to help me UNDERSTAND MORE ABOUT HOW PAIN HAS FIGURED IN YOUR LIFE IN GENERAL. (At this point, if the participant has not mentioned any experiences from adulthood, mention this and ask if there are any experiences from adulthood she or he cares to mention.) IS IT FAIR TO SUMMARIZE? WOULD YOU SAY, IN GENERAL? Mention any concentration of places, people, ways of behaving, ages, etc).

B. Are there any major experiences of pain you haven't mentioned? (Remind participant that she/he has the right to refuse to answer any questions-or to stop, especially if participant evidences discomfort).

A. RESOURCES

DA1: Do you talk to other people about (your) pain?

DA2:Who, if anyone, did you talk to about your (these) experiences of pain?

DA3:How do they deal with you?

DA4: What do they say?

DA5: What do they do?

DA6: How do they treat you?

DA7: Are they willing to spend time with you?

DA8: Are they willing to listen to you?

DA9: Can you think of some examples? (*Use to try to obtain examples.*)

DA10: Is this the way you would like to be treated?

DA11: Who, if anyone, helps you when you experience pain? (How many people can you (do you think) you can count on to help you when you experience pain?)

DA12: What do they do? (Repeated, in case thinking of who helps the participant helps the participant think of what these people do.)

DA13: Have you read anything to help you deal with this (these) experiences?

DA14: Do you ever use the Internet to help you deal with this (these) experiences?

B. NAMING, IDENTIFYING

DB1: Is there a name for what you experience?

DB2:How did you find out this was the name? (Who told you that there was a name?)

DB3: Has this been diagnosed? How? Do you think this is accurate?

DB4: How did that make you feel?

DB5: Is there anything you FELT, but couldn't seem to find the words for?
(RE: 'invented words', feminist perspective).

C. EXPERIENCES WITH PROFESSIONAL HEALTH CARE PERSONNEL

DC1: Did you consult any professionals to help you deal with this (these) experiences?

DC2: Who? (Doctor? Nurse? Health aide of some sort? Alternative health care person? Who?)

DC3: If so, did (do) this (these) professionals listen to you?

DC4: Do they do anything for you? To you?

E. EFFECTS ON AREAS OF LIFE

DE1: What areas of your life do you think the pain affected?

DE2:How does did this effect other areas of your life?

DE3: Did this affect your personal life? (Probe:Relations with friends? With partner? Marriage? Relations with children?)

Did this affect your work?.....employment? Ability to perform adequately in job? Ability to get your work done? Were absences from work necessary ?

DE 5: Did this have any effect on your choice of work?

DE6: Did this affect any major life events, (probe, if appropriate: Like leaving home? Going to school? Going to college?

DE7: Did this affect any leisure activities? Vacation choices? Hobbies?

F. VIEW OF SELF

DF1:Does this way of looking at your experience of pain make any difference to you, to your life?

DF2: Does this way of looking at your experience of pain help you in any way?

DF3: Does this way of looking at your experience of pain help you get on with your life?

DF4: How do you think you tolerate pain? If necessary, probe further: Do you think of yourself as someone who tolerates pain better or worse than most other people?)

DF5: Can you explain why this happened? (If necessary, probe: Why do you think this happened? What do you think caused this?)

DF6: Who, if anyone, do you think is responsible?

DF7: Do you think this affected the way you dealt with the pain?

DF8: To whom do you think you are talking in these narratives?

PART FIVE::CLOSING (SECTION E)

These questions are included to elicit any additional information and to provide closure for participants at the end of the interview.

Question E1: What were your expectations of this interview? What was it like to talk with me about these experiences of pain? What did you expect to happen in an interview about your experiences of pain?

Question E2: There is a lot we don't know about pain. Can you tell me if there is anything that you think is important for us to know about pain which I haven't asked about?

PART SIX: COPING STYLES QUESTIONNAIRE (See Attached Questionnaire)

Finally, would you please complete this brief questionnaire. It has fifty items

(Researcher will read the instructions at the beginning of the questionnaire to the participant) . I know that we have been talking for a while and I really appreciate your time and trouble. This is the last part of the interview and it should only take you about ten minutes to complete it.

After participant completes CSQ:

THAT'S THE WHOLE INTERVIEW. THANK YOU SO MUCH FOR YOUR HELP WITH THIS PROJECT.

I will need to refer to you by a name when I write the report. Would you like to choose your own name to be used in writing up the research?

Did you have any questions before we end our session? (Answer any questions)

Did you have any further comments? (Record any additional comments). Then thank you again.

I'd be happy to send you a copy of the abstract when the study is finished, so you can read about what I found out, if you'd like. (If participant is interested, record address so copy of abstract can be mailed).

Thank you.

Give participant \$20 promised, in envelope and have participant sign receipt. In cases where participants say they do not want to take the money, explain that the money has been allocated for this purpose, but, if they like, they can donate it to a charity, or just buy something small as a treat for themselves.

APPENDIX B COPING STRATEGIES QUESTIONNAIRE

Directions: Individuals who experience pain have developed a number of ways to cope, or deal, with their pain. These include saying things to themselves when they experience pain, or engaging in different activities. Below is a list of things that patients have reported doing when they feel pain. For each activity, I want you to indicate, using the chart below, how much you engage in that activity when you feel pain. A 0 indicates you never do that when you are experiencing pain, a 3 indicates that you sometimes do that when you are experiencing pain, and a 6 indicates that you always do that when you are experiencing pain. Remember, you can use any point along the scale.

0	1	2	3	4	5	6
Never			Sometimes			Always
do that			do that			do that

(To administer this instrument, it should be formatted so that the scale numbers appear beside each question)

When I feel pain...

1. I try to feel distant from the pain, as if the pain was in somebody else's body
2. I leave the house and do something, such as going to the movies or shopping.
3. I try to think of something pleasant.
4. I don't think of it as pain, but rather as a dull or warm feeling.
5. It's terrible and I feel it's never going to get any better.
6. I tell myself to be brave and carry on despite the pain.
7. I read.
8. I tell myself that I can overcome the pain.
9. I take my medication.
10. I count numbers in my head or run a song through my mind.
11. I just think of it as some other sensation, such as numbness.
12. It's awful and I feel that it overwhelms me.
13. I play mental games with myself to keep my mind off the pain.
14. I feel my life isn't worth living.
15. I know someday someone will be there to help me and it will go away for a while.
16. I walk a lot.
17. I pray to God it won't last long.
18. I try not to think of it as my body, but rather as something separate from me.
19. I relax.
20. I don't think about the pain.
21. I try to think of years ahead, what everything will be like after I've gotten rid of the pain.
22. I tell myself it doesn't hurt.
23. I tell myself I can't let the pain stand in the way of what I have to do.

24. I don't pay attention to the pain.
25. I have faith in doctors that someday there will be a cure for my pain.
26. no matter how bad it gets, I know I can handle it.
27. I pretend it's not there.
28. I worry all the time about whether it will end.
29. I lie down.
30. I reply in my mind pleasant experiences in the past.
31. I think of people I enjoy doing things with.
32. I pray for the pain to stop.
33. I take a shower or bath.
34. I imagine that the pain is outside of my body.
35. I just go on as if nothing happened.
36. I see it as a challenge and don't let it bother me.
37. Although it hurts, I just keep on going.
38. I feel I can't stand it anymore.
39. I try to be around other people.
40. I ignore it.
41. I rely on my faith in God.
42. I feel like I can't go on.
43. I think of things I enjoy doing.
44. I do anything to get my mind off the pain.
45. I do something I enjoy, such as watching TV or listening to music.
46. I pretend it's not a part of me.
47. I do something active, like household chores or projects.
48. I use a heating pad.
49. Based on all of the things you do to cope, or deal, with your pain, on an average day, how much control do you feel you have over it? Please circle the appropriate number. Remember, you can circle any number along the scale.

0	1	2	3	4	5	6
No			Some		Complete	
Control			control		control	

50. Based on all the things you do to cope, or deal, with your pain on an average day, how much are you able to decrease it? Please circle the appropriate number. Remember, you can circle any number along the scale.

0	1	2	3	4	5	6
Can't decrease at all		Can decrease somewhat		Can decrease completely		

Coping Strategies Questionnaire,
Scoring Key

Diverting Attention.....	3+10+13+30+31+43
Reinterpreting Pain Sensations.....	1+4+11+18+34+46
Coping Self Statements.....	6+8+23+26+36+37
Ignoring Sensations.....	20+22+24+27+35+40
Praying/Hoping.....	15+17+21+25+32+41
Catastrophizing.....	5+12+14+28+38+42
Increase Behavioral Activity.....	2+7+39+44+45+47
Filler Items (Not Scored).....	9,16,19, 29, 33, 48

APPENDIX C SCORING SHEET FOR NARRATIVES

Subject number _____ Narrative number _____

Pennebaker word count (plus Pain):

Pain _____
Positive emotion _____
Negative emotion _____
Causal _____
Insight _____

Leventhal components:

Label _____
Cause _____
Duration _____
Course _____
Curability _____

Gergen ingredients:

Valued Endpoint _____
Related Events _____
Temporal Ordering _____
Causal Linkages _____
Demarcation Signs _____

APPENDIX D TELEPHONE SCREENER FORM

For use when getting back to people after they contact researcher

The researcher will begin by introducing herself with the following introduction:

My name is Karen Steinmayer. I am a graduate student in the Ph.D. Program in Environmental Psychology at the Graduate Center of the City University of New York. I am the primary investigator on this research project which deals with people's everyday experiences. Before I explain more, I would just like to ask you a few brief questions to make sure that you are eligible to participate in this research project.

The researcher will first screen the potential participant by asking:

1.What is your age? (People must be ages eighteen (18) through fifty (50) to be eligible. If the person does not want to divulge age, ask **Are you aged eighteen through fifty?**

2.Do you have nay health problems? (Circle one) Yes No

*If the potential participant says that she or he **does** have a health problem (or problems) ask :I know that you do not know me and I don't want to pry. However, I'm going to ask you a few very brief questions about this health problem (problems). You have the right to refuse to answer any of these questions. None of this information will ever be used in connection with your name. If you don't participate in this study, this information will be shredded and disposed of immediately.*

Does this health condition have a name?

Does this health condition cause you any pain? If so, probe to ascertain if the pain meets the medical definition for chronic pain.

If the potential participant's health problems **do not** fit the medical definition of chronic pain, that is persists for more than six months or that it is constant for three months, **go on to Question 3.**

3. Do you have any problems which involve pain? (Circle one) Yes No

*If the potential participant says that she/he has problems which fit the medical criteria for chronic pain, pain lasting for more than six months or that is constant for three months, the researcher will thank the potential participant and apologize, saying, **(Go on to 3A):***

3A. Unfortunately, based on your answers to these questions, **you are not eligible to participate** in this research project. However, I am very grateful for your interest in my study. Thank you very much for your time and trouble.

If the potential participant says that she or he does not have any health conditions involving medically significant pain, the participant is eligible to participate in the study. The researcher will then describe the study to the participant and make arrangements to conduct the interview.

APPENDIX E E-MAIL USED IN PARTICIPANT RECRUITMENT

I am Karen Steinmayer, a doctoral student in the Environmental Psychology Program. For my doctoral dissertation I am working on a multi-method study of everyday life experience. Anyone from the ages of eighteen though fifty is eligible to participate. People who have participated in this study have said that they found it interesting and fun to do.

I am also offering twenty dollars to each participant, as a token of appreciation. I would be grateful to any of you who would be willing to participate yourselves. I would also be grateful if you would mention this study to any friends and acquaintances you think might be interested in participating.

If anyone would like to find out more about the study, and, possibly, participate in it, I can be reached by phone at: 212-614-0828 and by e-mail at: karismet@thomail.com. Please use the word "study" in the subject heading if you contact me by e-mail so I won't mistake e-mails from people I don't recognize as SPAM.

Thank you, in advance, for any help you can offer!
Karen

APPENDIX F**CONSENT FORM**

My name is Karen Steinmayer. I am a graduate student in the PhD Program in Environmental Psychology at the Graduate Center of the City University of New York. I am the Principal Investigator of this project, "Experiences of Pain in Everyday Life". The goal of this study is to help us develop a better understanding of people's experiences of pain. In order to do this, we are studying people's experiences of pain in as it occurs in the course of everyday life. I would like permission to interview you about some of your experiences. You will be able to choose the experiences you want to tell me about.

This interview should take approximately one and a half hours. I will ask you some questions about experiences of pain and I will ask you to do some writing telling me a little more about some experiences of pain. I will also ask you to do some drawings, illustrating some places where you have had experiences of pain in everyday life. Don't be concerned, talent in these areas is not necessary.

With your permission, I would like to tape this interview so I can be sure that I have recorded the details accurately. The tapes will be heard only by myself and my advisors. All the information collected, your answers to the questions in the interview, what you write about and your drawings, will be kept completely confidential. The information you provide will be given an identification number. Your name will never be used in any written reports on this study. No material from your interview which could possibly identify you will ever be used. All the interview material will be stored in a locked cabinet in my home to which only myself and my advisors have access.

Your participation in this study is strictly voluntary. You may choose not to answer any questions and you can withdraw from the study at any time.

While we do not anticipate that there is any risk to you from participating in this study, it is possible that you might experience some discomfort when thinking about experiences which involved pain. This should not be any greater discomfort than is experienced in the course of normal, daily life. In previous work in this area, we found that people sometimes say that they found it helpful to talk to someone about these experiences. However, if you are interested, I have put together a list of clinics which deal with issues of pain.

While the research may not benefit you directly, we hope that this information will help us to better understand people's experiences of pain and how they talk about them. The questions and activities in this study are designed for research purposes only. They are not designed to assess your mental or physical health in any way.

If you would like to receive a report of the findings, please provide me with your name and address and I will send you a report when I have analyzed the data.

If you have any questions about this research, you can call me at 212-817-8726, or e-mail me at: karismet@hotmail.com. You can also contact my advisor, Dr. Leanne Rivlin, at 212-817-8726 or e-mail her at: lrivlin@gc.cuny.edu. If you have questions about your rights as a research participant in this study, you can contact Hilry Fisher at the Office of Sponsored Research, the Graduate Center of the City University of New York, at 212-817-7523 or by e-mail at: hfisher@gc.cuny.edu.

Thank you for your participation. I will give you a copy of this Consent Form for your own records. As a token of our appreciation you will receive twenty dollars.

Consent statement: I have read the information above. The researcher has answered all questions I had to my satisfaction. She gave me a copy of this form. I consent to take part in the "Experiences of Pain in Everyday Life" study.

I agree to have this interview taped. [Please circle one] Yes No

Participant's
signature _____ Date _____

—

Witness _____ Date _____

Coping Strategies Questionnaire

468

Directions: Individuals who experience pain have developed a number of ways to cope, or deal, with their pain. These include saying things to themselves when they experience pain, or engaging in different activities. Below is a list of things that patients have reported doing when they feel pain. For each activity, I want you to indicate, using the chart below, how much you engage in that activity when you feel pain. A 0 indicates you never do that when you are experiencing pain, a 3 indicates you sometimes do that when you are experiencing pain, and a 6 indicates you always do it when you are experiencing pain. Remember, you can use any point along the scale.

0	1	2	3	4	5	6
Never			Sometimes			Always
Do That			Do That			Do That

When I Feel Pain . . .

1. I try to feel distant from the pain, as if the pain was in somebody else's body . 0 1 2 (3) 4 5 6
2. I leave the house and do something, such as going to the movies or shopping . 0 1 2 (3) 4 5 6
3. I try to think of something pleasant 0 1 2 (3) 4 5 6
4. I don't think of it as pain, but rather as a dull or warm feeling 0 1 2 3 4 (5) 6
5. It's terrible and I feel it's never going to get any better 0 1 (2) 3 4 5 6
6. I tell myself to be brave and carry on despite the pain 0 1 2 3 (4) 5 6
7. I read (0) 1 2 3 4 5 6
8. I tell myself that I can overcome the pain 0 1 2 3 4 (5) 6
9. I take my medication 0 1 2 3 4 (5) 6
10. I count numbers in my head or run a song through my mind 0 1 2 3 4 (5) 6
11. I just think of it as some other sensation, such as numbness 0 1 (2) 3 4 5 6
12. It's awful and I feel that it overwhelms me 0 1 (2) 3 4 5 6
13. I play mental games with myself to keep my mind off the pain 0 1 2 3 4 (5) 6
14. I feel my life isn't worth living (0) 1 2 3 4 5 6
15. I know someday someone will be here to help me and it will go away for awhile . 0 1 2 (3) 4 5 6
16. I walk a lot 0 1 2 (3) 4 5 6
17. I pray to God it won't last long (0) 1 2 3 4 (6) 6
18. I try not to think of it as my body, but rather as something separate from me . 0 1 2 (3) 4 5 6
19. I relax 0 1 2 3 (4) 5 6
20. I don't think about the pain 0 1 2 3 (4) 5 6
21. I try to think of years ahead, what everything will be like after I've gotten rid
of the pain 0 1 2 (3) 4 5 6
22. I tell myself it doesn't hurt 0 1 2 (3) 4 5 6

23. I tell myself I can't let the pain stand in the way of what I have to do 0 1 2 (3) 4 5 6
24. I don't pay any attention to the pain 0 1 2 (3) 4 5 6 469
25. I have faith in doctors that someday there will be a cure for my pain 0 1 2 (3) 4 5 6
26. No matter how bad it gets, I know I can handle it 0 1 2 3 (4) 5 6
27. I pretend it's not there 0 1 (2) 3 4 5 6
28. I worry all the time about whether it will end 0 1 (2) 3 4 5 6
29. I lie down 0 1 2 3 4 (5) 6
30. I replay in my mind pleasant experiences in the past 0 1 2 (3) 4 5 6
31. I think of people I enjoy doing things with 0 1 2 (3) 4 5 6
32. I pray for the pain to stop 0 1 2 3 4 5 (6)
33. I take a shower or a bath 0 1 2 (3) 4 5 6
34. I imagine that the pain is outside of my body 0 1 2 (3) 4 5 6
35. I just go on as if nothing happened 0 1 2 3 4 (5) 6
36. I see it as a challenge and don't let it bother me 0 1 2 3 (4) 5 6
37. Although it hurts, I just keep on going 0 1 2 3 (4) 5 6
38. I feel I can't stand it anymore 0 1 (2) 3 4 5 6
39. I try to be around other people 0 1 2 (3) 4 5 6
40. I ignore it 0 1 (2) 3 4 5 6
41. I rely on my faith in God (0) 1 2 3 4 5 6
42. I feel like I can't go on 0 (1) 2 3 4 5 6
43. I think of things I enjoy doing 0 1 2 (3) 4 5 6
44. I do anything to get my mind off the pain 0 1 2 3 (4) 5 6
45. I do something I enjoy, such as watching TV or listening to music 0 1 2 3 4 (5) 6
46. I pretend it's not a part of me 0 1 2 (3) 4 5 6
47. I do something active, like household chores or projects 0 1 2 (3) 4 5 6
48. I use a heating pad 0 (1) 2 3 4 5 6

49. Based on all of the things you do to cope, or deal with your pain, on an average day, how much control do you feel you have over it? Please circle the appropriate number. Remember, you can circle any number along the scale.

0	1	2	3	4	(5)	6
No			Some			Complete
Control			Control			Control

50. Based on all the things you do to cope, or deal with your pain on an average day, how much are you able to decrease it? Please circle the appropriate number. Remember, you can circle any number along the scale.

0	1	2	3	4	(5)	6
Can't Decrease			Can Decrease			Can Decrease
It At All			It Somewhat			It Completely

Press *BOB* *VIEW OF* *#19(1)*
Coping Strategies Questionnaire

470

Directions: Individuals who experience pain have developed a number of ways to cope, or deal, with their pain. These include saying things to themselves when they experience pain, or engaging in different activities. Below is a list of things that patients have reported doing when they feel pain. For each activity, I want you to indicate, using the chart below, how much you engage in that activity when you feel pain. A 0 indicates you never do that when you are experiencing pain, a 3 indicates you sometimes do that when you are experiencing pain, and a 6 indicates you always do it when you are experiencing pain. Remember, you can use any point along the scale.

0	1	2	3	4	5	6
Never			Sometimes			Always
Do That			Do That			Do That

When I Feel Pain . . .

1. I try to feel distant from the pain, as if the pain was in somebody else's body . 0 1 2 3 4 5 6
2. I leave the house and do something, such as going to the movies or shopping . 0 1 2 3 4 5 6
3. I try to think of something pleasant 0 1 2 3 4 5 6
4. I don't think of it as pain, but rather as a dull or warm feeling 0 1 2 3 4 5 6
5. It's terrible and I feel it's never going to get any better 0 1 2 3 4 5 6
6. I tell myself to be brave and carry on despite the pain 0 1 2 3 4 5 6
7. I read 0 1 2 3 4 5 6
8. I tell myself that I can overcome the pain 0 1 2 3 4 5 6
9. I take my medication 0 1 2 3 4 5 6
10. I count numbers in my head or run a song through my mind 0 1 2 3 4 5 6
11. I just think of it as some other sensation, such as numbness 0 1 2 3 4 5 6
12. It's awful and I feel that it overwhelms me 0 1 2 3 4 5 6
13. I play mental games with myself to keep my mind off the pain 0 1 2 3 4 5 6
14. I feel my life isn't worth living 0 1 2 3 4 5 6
15. I know someday someone will be here to help me and it will go away for awhile 0 1 2 3 4 5 6
16. I walk a lot 0 1 2 3 4 5 6
17. I pray to God it won't last long 0 1 2 3 4 5 6
18. I try not to think of it as my body, but rather as something separate from me . 0 1 2 3 4 5 6
19. I relax 0 1 2 3 4 5 6
20. I don't think about the pain 0 1 2 3 4 5 6
21. I try to think of years ahead, what everything will be like after I've gotten rid
of the pain 0 1 2 3 4 5 6
22. I tell myself it doesn't hurt 0 1 2 3 4 5 6

23. I tell myself I can't let the pain stand in the way of what I have to do 0 1 2 3 4 5 6 471
24. I don't pay any attention to the pain 0 1 2 3 4 5 6
25. I have faith in doctors that someday there will be a cure for my pain 0 1 2 3 4 5 6
26. No matter how bad it gets, I know I can handle it 0 1 2 3 4 5 6
27. I pretend it's not there 0 1 2 3 4 5 6
28. I worry all the time about whether it will end 0 1 2 3 4 5 6
29. I lie down 0 1 2 3 4 5 6
30. I replay in my mind pleasant experiences in the past 0 1 2 3 4 5 6
31. I think of people I enjoy doing things with 0 1 2 3 4 5 6
32. I pray for the pain to stop 0 1 2 3 4 5 6
33. I take a shower or a bath 0 1 2 3 4 5 6
34. I imagine that the pain is outside of my body 0 1 2 3 4 5 6
35. I just go on as if nothing happened 0 1 2 3 4 5 6
36. I see it as a challenge and don't let it bother me 0 1 2 3 4 5 6
37. Although it hurts, I just keep on going 0 1 2 3 4 5 6
38. I feel I can't stand it anymore 0 1 2 3 4 5 6
39. I try to be around other people 0 1 2 3 4 5 6
40. I ignore it 0 1 2 3 4 5 6
41. I rely on my faith in God 0 1 2 3 4 5 6
42. I feel like I can't go on 0 1 2 3 4 5 6
43. I think of things I enjoy doing 0 1 2 3 4 5 6
44. I do anything to get my mind off the pain 0 1 2 3 4 5 6
45. I do something I enjoy, such as watching TV or listening to music 0 1 2 3 4 5 6
46. I pretend it's not a part of me 0 1 2 3 4 5 6
47. I do something active, like household chores or projects 0 1 2 3 4 5 6
48. I use a heating pad 0 1 2 3 4 5 6

49. Based on all of the things you do to cope, or deal with your pain, on an average day, how much control do you feel you have over it? Please circle the appropriate number. Remember, you can circle any number along the scale.

0	1	2	3	4	5	6
No			Some			Complete
Control			Control			Control

50. Based on all the things you do to cope, or deal with your pain on an average day, how much are you able to decrease it? Please circle the appropriate number. Remember, you can circle any number along the scale.

0	1	2	3	4	5	6
Can't Decrease			Can Decrease			Can Decrease
It At All			It Somewhat			It Completely

Directions: Individuals who experience pain have developed a number of ways to cope, or deal, with their pain. These include saying things to themselves when they experience pain, or engaging in different activities. Below is a list of things that patients have reported doing when they feel pain. For each activity, I want you to indicate, using the chart below, how much you engage in that activity when you feel pain. A 0 indicates you never do that when you are experiencing pain, a 3 indicates you sometimes do that when you are experiencing pain, and a 6 indicates you always do it when you are experiencing pain. Remember, you can use any point along the scale.

	0	1	2	3	4	5	6
	Never Do That			Sometimes Do That			Always Do That
<i>When I Feel Pain . . .</i>							
1. I try to feel distant from the pain, as if the pain was in somebody else's body . . .	0	1	2	3	4	5	6
2. I leave the house and do something, such as going to the movies or shopping . . .	0	1	2	3	4	5	6
3. I try to think of something pleasant	0	1	2	3	4	5	6
4. I don't think of it as pain, but rather as a dull or warm feeling	0	1	2	3	4	5	6
5. It's terrible and I feel it's never going to get any better	0	1	2	3	4	5	6
6. I tell myself to be brave and carry on despite the pain	0	1	2	3	4	5	6
7. I read	0	1	2	3	4	5	6
8. I tell myself that I can overcome the pain	0	1	2	3	4	5	6
9. I take my medication	0	1	2	3	4	5	6
10. I count numbers in my head or run a song through my mind	0	1	2	3	4	5	6
11. I just think of it as some other sensation, such as numbness	0	1	2	3	4	5	6
12. It's awful and I feel that it overwhelms me	0	1	2	3	4	5	6
13. I play mental games with myself to keep my mind off the pain	0	1	2	3	4	5	6
14. I feel my life isn't worth living	0	1	2	3	4	5	6
15. I know someday someone will be here to help me and it will go away for awhile . . .	0	1	2	3	4	5	6
16. I walk a lot	0	1	2	3	4	5	6
17. I pray to God it won't last long	0	1	2	3	4	5	6
18. I try not to think of it as my body, but rather as something separate from me . . .	0	1	2	3	4	5	6
19. I relax	0	1	2	3	4	5	6
20. I don't think about the pain	0	1	2	3	4	5	6
21. I try to think of years ahead, what everything will be like after I've gotten rid of the pain	0	1	2	3	4	5	6
22. I tell myself it doesn't hurt	0	1	2	3	4	5	6

23. I tell myself I can't let the pain stand in the way of what I have to do 0 1 2 3 4 5 6 473
24. I don't pay any attention to the pain 0 1 2 3 4 5 6
25. I have faith in doctors that someday there will be a cure for my pain 0 1 2 3 4 5 6
26. No matter how bad it gets, I know I can handle it 0 1 2 3 4 5 6
27. I pretend it's not there 0 1 2 3 4 5 6
28. I worry all the time about whether it will end 0 1 2 3 4 5 6
29. I lie down 0 1 2 3 4 5 6
30. I replay in my mind pleasant experiences in the past P 0 1 2 3^M 4 5 6
31. I think of people I enjoy doing things with P 0 1 2 3^M 4 5 6
32. I pray for the pain to stop 0 1 2 3 4 5 6
33. I take a shower or a bath 0 1 2 3 4 5 6
34. I imagine that the pain is outside of my body M 0 1 2 3 4 5^P 6
35. I just go on as if nothing happened 0 1 2 3 4 5 6
36. I see it as a challenge and don't let it bother me 0 1 2 3 4 5 6
37. Although it hurts, I just keep on going 0 1 2 3 4 5 6
38. I feel I can't stand it anymore 0 1 2 3 4 5 6
39. I try to be around other people 0 1 2 3 4 5 6
40. I ignore it 0 1 2 3 4 5 6
41. I rely on my faith in God 0 1 2 3 4 5 6
42. I feel like I can't go on 0 1 2 3 4 5 6
43. I think of things I enjoy doing 0 1 2 3 4 5 6
44. I do anything to get my mind off the pain 0 1 2 3 4 5 6
45. I do something I enjoy, such as watching TV or listening to music 0 1 2 3 4 5 6
46. I pretend it's not a part of me M 0 1 2 3 4 5^P 6
47. I do something active, like household chores or projects 0 1 2 3 4 5 6
48. I use a heating pad 0 1 2 3 4 5 6

49. Based on all of the things you do to cope, or deal with your pain, on an average day, how much control do you feel you have over it? Please circle the appropriate number. Remember, you can circle any number along the scale.

0	1	2	3	4	<u>5</u>	6
No			Some			Complete
Control			Control			Control

50. Based on all the things you do to cope, or deal with your pain on an average day, how much are you able to decrease it? Please circle the appropriate number. Remember, you can circle any number along the scale.

0	1	2	3	<u>4</u>	5	6
Can't Decrease			Can Decrease			Can Decrease
It At All			It Somewhat			It Completely

References

- Abad, B. and Boyce, E. (1979). Issues in psychiatric evaluations of Puerto Ricans: A sociocultural perspective. *Journal of Operational Psychiatry*, 10, 28-39.
- Alexander, F. (1950). *Psychosomatic medicine*. New York: Norton.
- Bakhtin, M. M. (1986). *Speech genres and other late essays*. ed. Caryl Emerson and Michael Holquist, trans V. W. McGee. Austin: University of Texas Press.
- Bakhtin, M. M. (1981). *The dialogic imagination*. ed. Michael Holquist, trans. Caryl Emerson and Michael Holquist. Austin: University of Texas Press.
- Bandura, A. (1997). *Self-efficacy: The exercise of control*. New York: Freeman.
- Barker, R. (1968). *Ecological psychology: Concepts and methods for studying the environment of human behavior*. Stanford, CA: Stanford University Press.
- Barth, F. (1987). *Cosmologies in the making: A generative approach to cultural variation in Inner New Guinea*. Cambridge: Cambridge University Press.
- Becker, A.E. (1994). Nurturing and negligence: Working on others' bodies in Fiji. In T. Csordas (Ed.) *Embodiment and experience*. Cambridge: Cambridge University Press.
- Beecher, H. K. (1946). Pain in men wounded in battle. *The Bulletin of the U. S. Army Medical Department*, 5, (April, 1946), 445.
- Bekesy, G. von (1971). Localization of visceral pain and other sensations before and after anesthesia. *Perception and Psychophysics*, 9, 1-4.
- Bendelow, G. (1993). Pain perception, emotions and gender. *Soc. Health and Illness*, 15, 273-294.
- Benedict, R. (1923). The concept of the guardian spirit in North America. *Memoirs of the American Anthropological Association*, 29, 1-97.
- Bjerrum-Nielson, H. (1996). The magic writing pad: On gender and identity work. *Young Nordic Journal of Youth Research*, 4(3), 2-18.
- Bordo, S. (1990). Feminism, postmodernism and gender-skepticism. In L. J. Nicholson (Ed.) *Feminism/postmodernism*. 133-156. New York: Routledge.

- Bourdieu, P. (1977). *Outline of a theory of practice*. Cambridge: Cambridge University Press.
- Brown, L. M., and Gilligan, C. (1992). *Meeting at the crossroads: Women's psychology and girls' development*. Cambridge: Harvard University Press.
- Bruner, J. (1986). *Actual minds, possible worlds*. Cambridge, Mass.:Harvard University Press.
- Bruner J. (1990). *Acts of meaning*. Cambridge, Mass.:Harvard University Press.
- Bynum, C. (1992). *Fragmentation and redemption: Essays on gender and the human body in medieval religion*. New York: Zone.
- Candland, D. K. (1968). *Psychology: The experimental approach*. New York: McGraw-Hill.
- Carrigan, T. R., Connell, W., and Lee, J. (1985). Toward a new sociology of masculinity. *Theory and Society*, 14, 551-604.
- Changeux, J-P. (1985). *Neuronal man*. trans., L. Garey. New York: Pantheon.
- Chen, A. S. (1999). Lives at the center of the periphery, lives at the periphery of the center: Chinese American masculinities and bargaining with hegemony. *Gender and Society*, 13(5), 584-607.
- Clark, W. C. (2001). Pain and emotion. In J. Downey and E. Darling (Eds.). *Physiological basis of rehabilitation medicine*. 835-848. Boston: Butterworth/Heinemann.
- Clark, W. C. & Bennet-Clark, S. C. (1980). Pain responses in Nepalese porters. *Science*, 209, 440-442.
- Cole, J.J. and Paillard, J. (1995). Living without touch and peripheral information about body position and movement: Studies with deafferented subjects. In J.J.Bermudez, A. Marcel and N. Eilan (Eds.), *The body and the self*. Cambridge, MA: MIT Press.
- Colette (1907/1980). *Retreat from love*. Tr. Margaret Crosland. New York: Harcourt, Brace, Jovanovich.
- Csordas, T. (1994). *Embodiment and experience: The existential ground of culture and self*. Cambridge: Cambridge University Press.
- Csordas, T. (1990). Embodiment as a paradigm for anthropology. *Ethos*, 18, 5-47.

- Csordas, T. (1992). J. and Kleinman, A. (1990). The therapeutic process. In T. Johnson and C. Sargent (Eds.). *Medical anthropology: A handbook of theory and method*. 11-25. New York: Praeger.
- Ebigbo, P.O. (1982). Development of a culture specific (Nigerian) screening scale of somatic complaints. *Culture, Medicine and Psychiatry*. 6, 29-64.
- Edelman, G.M. (1987). *Neuronal Darwinism: The theory of neuronal group selection*. New York: Basic Books.
- Edelman, G. M. (1991). *Bright air, brilliant fire*. New York: Basic Books.
- Fabrega, H, and Tyma, S (1976a). Culture, language and the shaping of illness: An illustration based on pain. *Journal of Psychosomatic Research*, 20, 323-337.
- Fabrega, H. and Tyma, S. (1976b). Language and cultural influence in the description of pain. *British Journal of Medical Psychology*, 49, 349-371.
- Farmer, P. and Good, B. (1991). Illness representations in medical anthropology: A critical review and a case study of the representation of AIDS in Haiti. In J.A. Skeltons, R.T Croyle and R. Eiser (Eds.). *The mental representation of health and illness*.
- Fillingim, R. B., Edwards, R. R., & Powell, T. (1999). The relationship of sex and clinical pain to experimental pain responses. *Pain*, 83, 419-425.
- Fiori, G. [1970](1990). *Antonio Gramsci: Life of a revolutionary*. Reprint, New York: Verso.
- Fordyce, W. E. (1988). Pain and suffering: A reappraisal. *Am Psychol*, 43, 276-283.
- Foucault, M. (1973). *The birth of the clinic: An archeology of medical perception*. New York: Random House.
- Frank, A. W. (1995). *The wounded storyteller: Body, illness and ethics*. Chicago: The University of Chicago Press.
- Frank, A. W. (1991). For a sociology of the body: An analytical review. In M Featherstone, M. Hepworth and B. S. Turner, (Eds.) *The body: Social processes and cultural theory*. London: Sage Publications.
- Frank, G. (1986). On embodiment: A case study of congenital limb deficiency in American culture. *Culture, Medicine, and Psychiatry*, 10, 199-219.

- Freud, S. (1918). From the history of an infantile neurosis: An analytical review. In M. Featherstone, M. Hepworth and B. S. Turner (Eds.) *The body: Social process and cultural theory*. London: Sage Publications.
- Gardner, W.J., Licklider, J. C. R. and Weisz, A.Z. (1960). Suppression of pain by sound. *Science*, 132, 32-33.
- Gazzaniga, M. S. (1970). *The bisected brain*. New York: Appleton Century Crofts.
- Gergen, K and Gergen, M. (1988). Narrative and the self as relationship. In L. Berkowitz, (Ed.) *Advances in experimental social psychology*. San Diego: Academic Press. Giddens, A (1991). *Modernity and self-identity*. Stanford, CA.: Stanford University Press.
- Gijsbers, K. & Niven, C. A. (1995). Women and the experience of pain. In C. A. Niven and D. Carroll (Eds.). *The health psychology of women*. 43-57. Philadelphia: Harwood.
- Gilligan, C. (1982). *In a different voice: Psychological theory and women's development*. Cambridge: Harvard University Press.
- Gilligan, C., Lyons, N. P. and Hammer, T. J. (1990). *Making connections: The relational worlds of adolescent girls at Emma Willard School*. Cambridge: Harvard University Press.
- Good, B. J. (1994). *Medicine, rationality and experience: An anthropological perspective*. Cambridge: Cambridge University Press.
- Good, B. J. (1977). The heart of what's the matter: The semantics of illness in Iran. *Culture, Medicine and Psychiatry*, 1, 25-58.
- Good, M-J., Brodwin, P, Good, B. and Kleinman, A. (1992). *Pain as human experience: An anthropological perspective*. Berkeley: University of California Press.
- Good, B. J. and Good, M-J. (1980). The meaning of symptoms: A cultural, hermeneutic model for clinical practice. In L. Eisenberg and A. Kleinman, (Eds.) *The relevance of social science for medicine*. 165-196. Dordrecht, Holland: D. Reidel Publishing Co.
- Good, B.J., Good, M-J, and Moradi, (1985). The interpretation of dysphoric affect and depressive illness in Iranian culture. In A. Kleinman and B. J. Good (Eds.) *Culture and depression*. 369-428.

- Good, B. and Kleinman, A. (1985). Epilogue: Culture and depression. In A. Kleinman and B. Good, (Eds.) *Culture and depression*. 491-505.
- Goolkasian (1980). Cyclic changes in pain perception: An ROC analysis. *Perception and Psychophysics*, 27, 499-504.
- Gramsci, A. (1971). *Selections from prison notebooks*. New York: International.
- Greenhalgh, S. (2003). *Under the medical gaze: Facts and fictions of chronic pain*. Berkeley: University of California Press.
- Grosz, E. (1995). *Space, time and perversion: Essays on the politics of bodies*. New York: Routledge.
- Gullestad, M. (1996). *Everyday life philosophers*. Oslo: Scandinavian University Press.
- Haraway, D. (1991). *Simians, cyborgs and women: The reinvention of nature*. New York: Routledge.
- Harre, R. (1989). Language games and the texts of identity. In J. Shotter and K. Gergen, *Texts of identity*. London: Sage.
- Holland, D. (1997). Selves as cultured: As told by an anthropologist who lacks a soul. In R. A. Ashmore and L. Jussim (Eds.), *Self and identity: Fundamental issues*. New York: Oxford University Press.
- Heidegger, M. (1962). *Being and time*. Trans. E. Robinson and J. Macquarrie. New York: Harper and Row.
- Josselson, R. (1996). On writing other people's lives. In R. Josselson, (Ed.) *Ethics and process in narrative study of lives*. Thousand Oaks: Sage Publications.
- Katz-Rothman, B. (1982). *In labor: Woman and power in the birthplace*. New York: W. W. Norton Co.
- Keough, K. A., Garcia, J. and Steele, C. M. (1997). Reducing stress and illness by affirming the self. Manuscript under review.
- Klein, R. (1986). The dynamics of women's studies: Its international ideas and practices in higher education. Unpublished doctoral dissertation. University of London School of Education
- Kleinman, A. (1988). *The illness narratives: Suffering, healing and the human condition*. New York: Basic Books.

- Kleinman, A. (1982). Neurasthenia and depression: A study of somatization and culture in China. *Culture, Medicine and Psychiatry*, 6, 117-190.
- Kleinman, A. (1980a). *Social origins of pain and distress: Depression, neurasthenia and pain in modern China*. New Haven, Conn.; Yale University Press.
- Kleinman, A. (1980b). *Patients and healers in the context of culture*. Berkeley, Los Angeles: University of California Press.
- Kleinman, A. (1977). Depression, somatization and the new cross-cultural psychiatry. *Social Science and Medicine*, 11, 3-10.
- Kleinman, A. (1973). Medicine's symbolic reality: On the central problem in the philosophy of medicine. *Inquiry*, 16, 206-213.
- Kleinman, A. and Kleinman, J. (1991). Suffering and its professional transformation: Toward an ethnography of experience. *Culture, Medicine and Psychiatry*, 15, 275-301.
- Lackner, J. M., Carosella, A. & Feuerstein, M. (1996). Pain expectancies, pain and functional self-efficacy as determinants of disability in patients with chronic low back pain disorders. *Journal of Consulting and Clinical Psychology*, 64, 212-220.
- Lakoff, G. (1987). *Women, fire and dangerous things: What categories reveal about the mind*. Chicago: University of Chicago Press.
- Leenhardt, (1979) [1947]. *Do Kano: Person and myth in a Melanesian world*. Trans. Basia Miller Gulati. Chicago: University of Chicago Press.
- Leventhal, H. and Tomarken, A. (1986). Emotion: Today's problems. *Annual Review of Psychology*, 37, 565-610.
- Lindenbaum, S. and Lock, M. (Eds.) (1993). *Knowledge, practice and power*. Berkeley, CA: University of California Press.
- Lock, M. (1999). The politics of health, identity and culture. In R. J. Contrada and R. D. Ashmore (Eds.), *Self, social identity and physical health*. 43-68. New York: Oxford University Press.
- Lock, M. (1990). On being ethnic: The politics of identity making and breaking in Canada or Nevra on Sunday. *Culture, Medicine and Society*, 14, 237-254.
- Lock, M. and Gordon, D. (1988). *Biomedicine examined*. Dordrecht, Holland: Kluwer Academic Publishers.

- Lock, M. and Scheper-Hughes, N. (1990). A critical-interpretive approach in medical anthropology: Rituals and routines of discipline and dissent. In T. Johnson and C. Sargent (Eds.). *Medical anthropology: A handbook of theory and method*. 47-72.
- Lock, M. and Wakewich-Dunk, P. (1990). Nerves and nostalgia: The expression of distress among Greek-Canadian immigrant women. *Canadian Family Physician*, 36, 253-258.
- Loeser, J. D. (1980). Perspectives on pain. In *Proceedings for First World Conference on Clinical Pharmacology and Therapeutics*. London: Macmillan. 313-316.
- Lorenzer, A. (1986). Tiefenhermeneutische Kulturanalyse. In H. D. K'nig et al., *Kulturanalysen*. Frankfurt an Main: Fischer Verlag.
- Low, S. M. (1989). Gender, emotion and nervios in urban Guatemala. *Health Care for Women International*, 10, 115-140.
- Low, S. M. (1985). Culture bound syndromes or culturally interpreted symptoms. *Social Science and Medicine*, 12, 187-196.
- Lutz, C. (1988). *Unnatural emotions: Everyday sentiments on a Micronesian atoll and their challenge to Western theory*. Chicago: University of Chicago Press.
- Lutz, C. and White, G. M. (1986). The anthropology of emotions. *Annual Review of anthropology*, 15, 405-536.
- Martin, E. (1987). *The woman in the body*. Boston: Beacon.
- Martin, E. (1992). The end of the body? *American Ethnologist*, 19, 121-40.
- Marty, P and de M'Uzan, M. (1963). La pensee operateire. *Revue Francais de Psychoanalyse*, 27, 1345-1356.
- Mauss, M. (1950). *Les techniques du corps: Sociologie and anthropologie*. Paris: Presses Universitaires de France.
- McDougall, J. (1980). *Plea for a measure of abnormality*. New York: International Universities Press. (original work published 1978).
- McLean, P.D. (1949). Psychosomatic stress and the "visceral brain". *Psychosom. Med.*, 11, 338-353.

- Melzack, R. (1973). *The puzzle of pain*. New York: Basic Books.
- Melzack, R. (1970). Phantom limbs. *Psychology Today*, 4, 63-68.
- Melzack, R. and Casey, K. L. (1968). Sensory, motivational and control determinants of pain: a new conceptual model. In D. Kenshalo (Ed.). *The skin senses*. London: Macmillan. 423-435.
- Melzack, R. and Wall, D. P. (1983). *The challenge of pain*. New York: Basic Books.
- Melzack, R. and Wall, D. P. (1965). Pain mechanisms: A new theory. *Science*, 150, 971-979.
- Merleau-Ponty, M. (1962). *Phenomenology of perception*. Trans. J. Edie. Evanston, Ill.: Northwestern University Press.
- Morris, D.B. (1991). *The culture of pain*. Berkeley: University of California Press.
- Nehemiah, J. C. and Sifneos, P. E. (1973). Affect and fantasy in patients with psychosomatic disorders. In O.W. Hill (Ed.) *Modern trends in psychosomatic medicine*. London: Butterworths.
- Obeyesekere, G. (1990). *The work of culture*. Chicago: The University of Chicago Press.
- Ots, T. (1991). Phenomenology of the body: The subject-object problem in psychosomatic medicine and the role of traditional medical systems. In B. Pflederer and G. Bribeau (Eds.) *Anthropologies of medicine: A colloquium of West European and North American perspectives*. Special issue of *Curare*. Weisbade: Weiweg. 43-58.
- Ots, T. (1990). The angry liver, the anxious heart, and the melancholy spleen: The phenomenology of perceptions in Chinese culture. *Culture, Medicine and Psychiatry*, 4, 21-58.
- Pennebaker, J. W. (1997). *Opening up: The healing power of expressing emotions*. (2nd ed.) New York: Guilford.
- Phoenix, A, Frosch, S. and Puttman, R. (2003). Producing contradictory masculine subject positions: Narratives of threat, homophobia and bullying in 11-14 year old boys. *Journal of Social Issues*, 59 (1), 179-195.
- Pollack, W. (1998). *Real boys: Rescuing our sons from the myth of boyhood*. New York: Henry Holt.

- Pred, A. (1985). The social becomes the spatial, the spatial becomes the social: Enclosures, social change and the becoming of places in the Swedish province of Skane. In D. Gregory and J. Urry, (Eds.), *Social relations and spatial structures*. New York: St. Martin's Press.
- Pred, A. (1984). Place as historically contingent process: Structuration and the time-geography of becoming places. *Annals of the Association of American geographers*, 74, 279-297.
- Pred, A. (1983). Structuration and place: On the becoming sense of place and structure of feeling. *Journal for the Theory of Social Behavior*, 13, 45-68.
- Prokop (1996). Cultural patterns of the feminine-On the construction of the ideal woman in Rousseau. In U. Prokop, *Kvinnelighetens symbolikk-kvinnelige livsutkast i det moderne* (Arbeidsnotar 7). Oslo:Centre of Women's Studies, University of Oslo.
- Reinharz, S (1992). *Feminist methods in social research*. New York: Oxford University Press.
- Reiser, S. J. (1978). *Medicine and the reign of technology*. New York: Cambridge University Press.
- Ricoeur, P. (1991). Life in quest of a narrative. In D. Wood (Ed.), *On Paul Ricoeur: Narrative and interpretation*. London: Routledge.
- Riley, J. L., Robinson, M. F., Wise, E. A., Myers, C. D. & Fillingim, R. B. (1998). Sex differences in the perception of noxious experimental stimuli: A meta-analysis. *Pain*, 74, 181-187.
- Robinson, M.E., Riley III, J. F. & Myers, C. D. (2000). Psychosocial contributions to sex-related differences in pain responses. In R. B. Fillingim (Ed.), *Sex, gender and pain: Progress in pain research and management*. Seattle: IASP Press. 41-68.
- Rosaldo, M. and Lamphere, L. (Eds.) (1974). *Women, culture and society*. Stanford: Stanford University Press.
- Rosenwald, G. C. (1992). Conclusion: Reflections on narrative self-understanding. In G. C. Rosenwald and R. L. Ochberg, (Eds.), *Storied lives: The cultural politics of self-understanding*. New Haven: Yale University Press.
- Ruesch, J. (1957). *Disturbed communication*. New York: W. W. Norton and Co.

- Scarry, E. (1985). *The body in pain: The making and unmaking of the world*. New York: Oxford University Press.
- Schafer, R. (1992). *Reading a life: Narration and dialogue in psychoanalysis*. New York: Basic Books.
- Scheper-Hughes, N. (1992). *Death without weeping: The violence of everyday life in Brazil*. Berkeley: University of California Press.
- Scheper-Hughes, N. & Lock, M. (1987). The mindful body: A prolegomenon to future work in medical anthropology. *Medical Anthropology Quarterly*, 1, 6-41.
- Searle, J. R. (1983). *Intentionality: An essay in the philosophy of mind*. New York: Cambridge University Press.
- Sifneos, P. E. (1973). The prevalence of alexithymic characteristics in psychosomatic patients. *Psychother. Psychosom.*, 22, 255-62.
- Spence, D. P. (1982). *Narrative truth and historical truth: Meaning and interpretation in psychoanalysis*. New York: Norton.
- Steinmayer, K. M. (2001). Maps, narratives and health. Unpublished master's thesis. The Graduate Center of the City University of New York.
- Steinmayer, K. M. and Millery, M. (1999). *Do the data speak? Invited presentation, The Developmental Psychology Colloquium Series*, The Graduate Center, CUNY, March, 1999.
- Sullivan, M. J. L., Tripp, D. A. & Santor, D. (2000). Gender differences in pain and pain behavior: The role of catastrophizing. *Cognitive Therapy and Research*, 24, 121-134.
- Taylor, C. (1989). *Sources of the self*. Cambridge, MA: Harvard University Press.
- Taylor, G. J. (1987). *Psychosomatic medicine and contemporary psychoanalysis*. New York: International Universities Press.
- Taylor, G. J., Bagby, R. M., Parker, J. D. A. (1991). The alexithymia construct: A potential paradigm for psychosomatic medicine. *Psychosomatics*, 32, 153-161.
- Taylor, S. (1995). *Health psychology*. (3^{rd.ed.}) New York: McGraw-Hill.
- Webster's Ninth Collegiate Dictionary (1990) Merriam Webster, Inc.

Worthman, C. (1992). Cupid and psyche: Investigative sycrretism in biological and psychosocial anthropology. In T. Schwartz, G.M. White and C. A. Lutz (Eds.) *New directions in psychological anthropology*. Cambridge: Cambridge University Press.

Wrong, D. (1961). The oversocialized conception of man in modern sociology. *American Sociological Review*, 26, 183-193.

Zborowski, M. (1969). *People in pain*. San Francisco: Jossey-Bass.

Zborowski, M. (1952). Cultural components in response to pain. *Journal of Social Issues*