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Preface

This study forms part of an interdisciplinary research project entitled “Den psykologiske, sociale og kulturelle forståelse af angst, depression og smerte i befolkning og sundhedsvæsen” (The psychological, social and cultural understanding of anxiety, pain and depression in the population and the health care system), funded by the Danish Research Council (no. 9600253 and 2035-00-0007). The project was supervised by Erik Friis-Hasché, dr. odont, former head of research at the *Medicinske Forskningsenhed, Ringkøbing County, Denmark. Part of the study carried out for this article was funded by this larger project and part of it was funded by the local fund “Den samfundsmedicinske forskningsfond for Ribe og Ringkøbing Amter” (Social Science Research fund for Ribe and Ringkøbing Counties), no. 2-44-4-14-99.

Several professionals have inspired this study. I am indebted to Dr. Odont Erik Friis-Hasché, who initially hired me to do the job. My colleagues in The Occupational Health Clinic, Herning Hospital, Denmark generously offered supervision. Last but not least social anthropologists Jørgen Østergaard Andersen and Trine Dalsgaard has offered lengthy discussions on the subject of the paper. The final result, with whatever shortcomings, however, remains mine entirely.
Musculoskeletal Complaints. An Ethnographic Study of Lay Knowledge

_Lise Hildebrandt-Eriksen_

Abstract

This paper offers an explorative study of the common complaint of pain in muscles and joints. The aim of the study is to present the practical knowledge of persons with musculoskeletal pain in order to localize social and moral issues in their expression and management of everyday pain. The paper presents the practical knowledge of twenty persons with musculoskeletal pain, and then it discusses the findings according to the interpretive concepts of doxa, risk, blame, ‘passing’ and authority. The study concludes that the participants exhibit considerable practical creativity in dealing with their complaints in everyday life, but they are also faced with the constraints of an authority imbalance in the communication that takes place in clinical settings and the risk of stigmatization in the wider social context of their everyday lives.

Key words: authority, blame, body, compliance, complaint, culture, doxa, knowledge, musculoskeletal pain, health care, risk, stigma.
1. Introduction

According to the Danish National Institute of Epidemiological Research (DIKE), musculoskeletal complaints are one of the most common health complaints in the Danish population, leading to a reduced level of activity for the individual, the use of medication and visits to medical practitioners as well as to sick leave and marginalisation from the work force (Brinck et al. 1995: 9-11). Working life is seen as a risk factor for developing musculoskeletal disabilities and complaints, which is mainly found among persons in lower socio-economic groups (Ibid: 96-104). Musculoskeletal pain is in most cases managed by the individual without assistance from professionals. Those who seek medical attention are more burdened by their pain than those who do not seek biomedical attention. Fourteen percent of those who seek medical attention are not satisfied with the results of their consultations. The most common causes of dissatisfaction are incorrect treatment, lack of trust and insufficient consultation time. Dissatisfaction arises mainly in connection with treatment in hospitals and by specialist doctors (Ibid.: 105-135).

The individual as well as the societal burdens of musculoskeletal pain are thus obvious. As most episodes of musculoskeletal complaint are handled outside the
professional health care sector, little is known about the knowledge at stake in dealing with complaints and about the social and moral implications of that knowledge. An ethnographic inquiry into musculoskeletal pain unfolds issues of self-perception, prevention, caring and compliance as experienced by the inflicted.

The presentation of the experience of physical, social and moral issues associated with musculoskeletal pain in this paper is based on a study of transcribed single interviews with nine men and eleven women of different ages with various degrees of musculoskeletal pain.

The exploration into the participants’ lay knowledge was formed as an inquiry into three basic research questions: 1) What are the participants’ sources of knowledge of musculoskeletal pain? 2) What is the nature of that knowledge? 3) Which moral issues can be traced in the participants’ knowledge of musculoskeletal pain? In order to answer these questions, the present study presents the results of the inquiry according to the categories of ‘etiology’, ‘consequence’, ‘origin’ and ‘knowledge’. The findings are then discussed in the final section of the paper along the interpretative concepts of doxa, risk, blame, ‘passing’ and authority.
2. Method

*Investigative procedures and ethics*

Interviews were conducted in the homes of eighteen participants and two participants were interviewed in the office of the research institution. An interview guide containing the following themes was prepared: 1) life history, 2) working life, 3) description of health, 4) description of symptoms, 5) treatment, 6) description of daily life, 7) expectations for the future. The interview guide along with the questionnaire that the participants had already answered proved useful in initiating the conversation between participant and researcher. In practice, however, the interview was carried out around themes that evolved as the interview took shape based on a description of the pain from the questionnaire. Throughout the interview the researcher posed open-ended, descriptive, contrastive and interpretive questions.

Interviews were tape recorded and transcribed verbatim. The interview material was then coded back and forth between 'emic' and 'etic' categories in a hermeneutic interpretive cycle. I take 'emic' to mean categories close to the perspective of the participants aimed at securing the authenticity of their
perspective, and 'etic' to be anthropological categories localised or constructed in the process of interpretation (Geertz 1993: 56-57).

A representative selection of participants was recruited from respondents to a questionnaire on musculoskeletal pain mailed to 1010 citizens in Ringkøbing County. 232 (105 men and 126 women and one of unknown gender) gave positive answers to questions concerning musculoskeletal pain, and 155 of these agreed to participate in further interviews. A random sample of twenty participants was selected for the interviews. The twenty participants for the interviews display the same characteristics concerning musculoskeletal complaint as the larger group of 232 respondents who gave positive answers to questions concerning musculoskeletal complaints.

Throughout the paper the terms “musculoskeletal complaint” and “pain” are used synonymously to refer to the particular health problem presented by the participants in this study.

The study was presented for the local ethics committee, which approved of the protocol.
Theoretical underpinnings and concepts of the study

I take the standpoint that the participants’ knowledge of their musculoskeletal complaints can be comprehended as a particular form of practical knowledge which reveals moral issues for the inflicted, including issues concerning treatment, medical consultation and prevention. The theoretical underpinnings of this point of departure are supported in part by Barth’s definition of culture as knowledge and in part by Bourdieu’s concept of doxa. The study is conceptually inspired by Kleinman’s three-part model of the health care system. Barth defines culture as knowledge, concepts and values which are manifested, created and negotiated in different spheres of life (Barth 1993; 1995). The major task of ethnography, according to Barth, is to discover and give an account of people’s acts in different contexts, and to understand the variation, practice and creativity of knowledge in order to unravel whatever connections and constraints direct the lives and meanings of people (Barth 1993: 173; 1995:66-67). Thus Barth points towards the relevance of paying attention to the eruption of the disorderly aspects of society. In this context pain may be seen as a disruption which manifests itself in individuals who possess knowledge of that pain – knowledge which is also tacit and implicit for the inflicted.
Bourdieu’s concept of doxa is useful in approaching an understanding of the implicit knowledge of musculoskeletal pain. Doxic knowledge belongs to the universe of undiscussed or undisputed experiences (Bourdieu 1977: 168). It is the self-evident and matter-of-course presuppositions of bodily knowledge. The commonsense world is self-evident and what is essential goes without saying because it comes without saying: tradition is silent, not least about itself (Bourdieu 1977: 166-171; 1990: 67-68). Understanding doxic knowledge requires attention to the silent and implicit knowledge that flows from practical sense (Bourdieu 1990: 68). For most of the participants in this study, talking about and describing their complaints in the interview was the first time they put into words their otherwise silent and implicit knowledge.

Knowledge inherent in explanatory models of laypersons, according to Kleinman, is characterised by vagueness, a multiplicity of meanings, frequent changes, and a lack of sharp boundaries between ideas and experiences (Kleinman 1980: 107). According to Kleinman, this is because lay persons are not used to giving lengthy accounts to medical practitioners of their health complaints, since they fear or have experienced being ridiculed, criticized or intimidated, or are embarrassed about their own homemade explanation (Kleinman 1980: 106). Kleinman’s work on
patients’ explanatory models as well as his three-part model of the health care system inspired the interview as well as the categories used in the presentation of the results (Kleinman 1980: 50; 105-106). I have, however, attempted to construct emic categories emanating from the interpretation of the interviews rather than adapting the findings to Kleinman’s clinical categories.

Sections 4 – 6 present the participants’ knowledge of the sensory manifestation, consequences and origins of pain. Sections 7 – 9 present the participants’ knowledge of how to deal with pain in the three sectors of the health care system. In this paper, the folk sector refers to the intimate spheres of life including the family, the popular sector includes various kinds of healers not sanctioned by health authorities as well as sports and fitness centers, and the professional sector comprises all kinds of authorized health practitioners (Kleinman 1980: 50).

3. Overview of the participants

The following two figures offer an overview of the participants in this study, one of which provides information on musculoskeletal complaints and the other sociodemographic information about the participants.
Fig. 1. Musculoskeletal pain according to participants’ responses to questionnaire.

<table>
<thead>
<tr>
<th>ID nr.</th>
<th>1. Pain or complaint from shoulder or neck</th>
<th>2. Pain in or complaint about back and lower back</th>
<th>3. Pain in or complaint about arm, hands, leg, knee, hips or joints</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes, a little</td>
<td>Yes, a lot</td>
<td>No</td>
</tr>
<tr>
<td>67</td>
<td>+</td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>115</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>118</td>
<td>+</td>
<td></td>
<td>5 months</td>
</tr>
<tr>
<td>128</td>
<td>+</td>
<td></td>
<td>4 months</td>
</tr>
<tr>
<td>160</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>172</td>
<td>+</td>
<td></td>
<td>30 years</td>
</tr>
<tr>
<td>183</td>
<td>“many years”</td>
<td>+</td>
<td>“many years”</td>
</tr>
<tr>
<td>218</td>
<td>+</td>
<td></td>
<td>15 years</td>
</tr>
<tr>
<td>326</td>
<td>+</td>
<td></td>
<td>6 years</td>
</tr>
<tr>
<td>391</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>411</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>474</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>483</td>
<td>+</td>
<td></td>
<td>“on and off”</td>
</tr>
<tr>
<td>490</td>
<td>+</td>
<td></td>
<td>15 years</td>
</tr>
<tr>
<td>520</td>
<td>+</td>
<td></td>
<td>2.5 months</td>
</tr>
<tr>
<td>584</td>
<td>+</td>
<td></td>
<td>3 years</td>
</tr>
<tr>
<td>602</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>658</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>893</td>
<td>+</td>
<td></td>
<td>1 week</td>
</tr>
<tr>
<td>944</td>
<td>+</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Fig. 2. Sociodemographic characteristics of participants and pain-related event(s).

<table>
<thead>
<tr>
<th>ID nr.</th>
<th>Sex</th>
<th>Age</th>
<th>Marital status</th>
<th>Occupation</th>
<th>Context of work</th>
<th>Pain-related event(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>67</td>
<td>Male</td>
<td>19</td>
<td>Single</td>
<td>Unskilled worker</td>
<td>Works in garage</td>
<td>Sports, work overstrain, resting.</td>
</tr>
<tr>
<td>115</td>
<td>Fem.</td>
<td>54</td>
<td>Married</td>
<td>Cleaner</td>
<td>Works in a primary school</td>
<td>Repetitive strain in work</td>
</tr>
<tr>
<td>118</td>
<td>Fem.</td>
<td>51</td>
<td>Married</td>
<td>School teacher</td>
<td>Works as vice manager in primary school</td>
<td>Repetitive strain in working with computer</td>
</tr>
<tr>
<td>128</td>
<td>Fem.</td>
<td>19</td>
<td>Single</td>
<td>Unskilled worker</td>
<td>Works on a farm</td>
<td>Sudden movements, kicked by horses, allergic reaction to wild plant.</td>
</tr>
<tr>
<td>160</td>
<td>Fem.</td>
<td>51</td>
<td>Married</td>
<td>Accountant</td>
<td>Works in a municipal department</td>
<td>Sports in childhood</td>
</tr>
<tr>
<td>172</td>
<td>Fem.</td>
<td>67</td>
<td>Married</td>
<td>Retired from work as shopkeeper</td>
<td>Recently retired</td>
<td>Sitting on hard chair</td>
</tr>
<tr>
<td>183</td>
<td>Male</td>
<td>37</td>
<td>Married</td>
<td>Skilled worker</td>
<td>Works in a textile factory</td>
<td>Duration of repetitive strain in work</td>
</tr>
<tr>
<td>218</td>
<td>Male</td>
<td>55</td>
<td>Married</td>
<td>Unskilled worker</td>
<td>Works in an outdoor training camp</td>
<td>Duration of repetitive work.</td>
</tr>
<tr>
<td>326</td>
<td>Fem.</td>
<td>18</td>
<td>Single</td>
<td>Recently completed high school</td>
<td>Unemployed</td>
<td>Duration of mocking in school.</td>
</tr>
<tr>
<td>391</td>
<td>Male</td>
<td>43</td>
<td>Married</td>
<td>School teacher</td>
<td>Works as vice manager in primary school</td>
<td>Lifting heavy burdens at home</td>
</tr>
<tr>
<td>411</td>
<td>Male</td>
<td>28</td>
<td>Single</td>
<td>Salesman</td>
<td>Works in a private firm</td>
<td>Duration of car driving, work overload</td>
</tr>
<tr>
<td>474</td>
<td>Male</td>
<td>33</td>
<td>Married</td>
<td>Unskilled worker</td>
<td>Works in an abattoir</td>
<td>Computer work, falling from broken chair</td>
</tr>
<tr>
<td>483</td>
<td>Fem.</td>
<td>26</td>
<td>Single</td>
<td>Artisan</td>
<td>Works in a production plant</td>
<td>Unspecified illness</td>
</tr>
<tr>
<td>490</td>
<td>Fem.</td>
<td>46</td>
<td>Married</td>
<td>Sewing machine operator</td>
<td>On disability pension</td>
<td>Duration of repetitive strain in work</td>
</tr>
<tr>
<td>520</td>
<td>Fem.</td>
<td>60</td>
<td>Married</td>
<td>Sewing machine operator</td>
<td>Retired</td>
<td>Resting, duration of work overstrain</td>
</tr>
<tr>
<td>584</td>
<td>Fem.</td>
<td>36</td>
<td>Married</td>
<td>Unskilled worker</td>
<td>Works in a factory</td>
<td>Lifting heavy burdens, menstruation.</td>
</tr>
<tr>
<td>602</td>
<td>Fem.</td>
<td>53</td>
<td>Married</td>
<td>Shopkeeper</td>
<td>Works as a shopkeeper</td>
<td>Dislocating joints in previous work as nurse in hospital.</td>
</tr>
<tr>
<td>658</td>
<td>Male</td>
<td>56</td>
<td>Married</td>
<td>Skilled worker</td>
<td>Works in a factory</td>
<td>Lifting something, damaged back in childhood</td>
</tr>
<tr>
<td>893</td>
<td>Male</td>
<td>20</td>
<td>Single</td>
<td>Baker</td>
<td>Works in a bakery</td>
<td>Lifting burdens, standing at work, dislocating knee in sports</td>
</tr>
<tr>
<td>944</td>
<td>Male</td>
<td>50</td>
<td>Lives with girlfriend</td>
<td>Skilled worker</td>
<td>Works in a communication business</td>
<td>Falling accident at work, knee damage in sports.</td>
</tr>
</tbody>
</table>
The information that the participants provided in the questionnaire shown in fig. 1 is part of a process of knowledge production. Knowledge revealed in a questionnaire like the one used here tells about signs, experiences and outcomes. It is not related to the social life of the individuals. A major task of this paper is to fit this information into the situational and biographical context of the participants. Fig. 2 shows some of that context in a schematic form. The rest of this paper explores in more detail the cultural knowledge of the participants.

4. The body as a source of knowledge

For the inflicted pain is experienced as a physical sensation. In the process of interpretation the sensation of pain produces knowledge about the manifestation, movement, intensity and timing of pain. The study presents the results of the exploration of participants’ accounts of their sensory knowledge of pain according to the following four categories: 1) etiology, 2) intensity of pain, 3) movement of pain in the body and 4) timing and duration of pain.
Etiology

Etiological labels for pain are labels which participants use to assign an overall name to their pain. Pain is commonly reified as an “it”. The participants’ stress the reification of pain by describing it as similar to being stung by needles or as a foreign source coming from without. One woman used “witch” as a metaphor for pain. The “witch” metaphor for pain may be seen as one variation of the reification of pain. The pain may arise from inside the body or it may be experienced as something striking the body from without. In any case, pain is experienced as something that disturbs an otherwise harmonic state of the body and gives rise to a more or less chaotic state.

When participants named their pain it was most commonly called “soreness”, and “infiltrations of the muscles” or simply “back troubles”. They used labels such as “cold shoulder”, “golf arm” or “poor joints” as well as categories such as “arthritis”, “ischias”, and “slipped disc”. For the participants, however, labelling the pain was not a central issue; rather they were concerned about how to describe their knowledge of how pain functioned in their body as well as the origins and consequences of their pain.
The process of labelling pain is connected with searching for an explanation for the pain. This involves searching in the area of biomedical knowledge – in these cases consulting the general practitioner. Some participants indicated that they had been provided with biomedical diagnoses of their pain such as “allergy”\textsuperscript{12} or “calcification of the limbs”\textsuperscript{13} – diagnoses which in the minds of the participants referred to the cause of their complaint. Other sources of inspiration for the labelling of their pain are the media, which offer accounts of popularized medical and psychological knowledge. At the time when these interviews were conducted some of the female participants were influenced by a much cited Danish neuropsychologist who wrote a bestseller on somatizing women, which led some to reflect on their pain along the lines of what the psychologist idiomatically calls a “life-ache”,\textsuperscript{14} referring to somatization (Ehlers 2000).

\textit{Intensity of pain}

The participants experienced a varying intensity of pain, as is also evident in fig. 3. Participants described their pain using sensory terms ranging from “sore”\textsuperscript{15} to “it hurts”\textsuperscript{16} to “shooting”.\textsuperscript{17} Pain may be sensed as a feeling of “sleepiness” or “numbness”\textsuperscript{18} in a particular muscle area, as a “long round thing in your back – like ice”,\textsuperscript{19} as a “sting”,\textsuperscript{20} “feeling of unrest”\textsuperscript{21} in a particular limb, a “stiffness”,\textsuperscript{22} a
feeling of “tension in the muscle”\textsuperscript{23} and “hardness in the muscles”\textsuperscript{24}. One woman made a clear distinction between pain in her muscles and pain in her joints. Muscle pain feels like the “muscles are too short” or simply “aching”\textsuperscript{25} and the pain may be eased by moving or massaging the afflicted muscles, whereas pain in the joints has a more persistent quality: “it is”.

Pain is described as a “crack in the joints”\textsuperscript{26} which may release a more persistent episode of pain. Pain is also described as a “burning sensation”\textsuperscript{27} or “dull pain”\textsuperscript{28}. One participant described a pain so intense and awful that “it feels as if someone is turning knives around in your knee”\textsuperscript{29}.

\textit{Movement of pain in the body}

Some participants experienced pain as persistent and residing in a particular area of the body. But pain is seldom experienced as constant, as something that may be localized to a concise small spot. Pain is frequently described as starting from a particular area of the body, for instance the neck, and spreading to a wider area, either the head or shoulders, or just as frequently, starting in the back and moving downward, “radiating out into the buttocks”\textsuperscript{30}. One woman described the spread of pain in her body this way: “[since] there are so many muscles the pain can be quite
terrible in your body. And since muscles do not live alone, all of them are connected, the problem may originate from a different place than were the pain is”\(^{31}\). Pain in a joint may move from limb to limb and is worsened by physical movement.

It seems a glaring paradox that pain may also be worsened by motionlessness, turning rest and sleep into a episode of pain. Being inflicted with muscle and joint pain at the same time means that bodily techniques of easing the muscle pain automatically worsen the joint pain and vice versa\(^ {32}\).

*Timing and duration of pain*

Pain may be experienced as a constant and persistent quality – for instance, for the participant who said: “there is not a single day when I am not in pain”\(^ {33}\). Others may experience pain as “coming and going in turns”\(^ {34}\). Pain may come suddenly without prior warning. Episodes of pain in one area of the body may start an episode of pain in another area – an episode lasting days, weeks, months or years. One elderly participant found that the intensity of her pain had subsided after she retired from work\(^ {35}\). Another elderly participant, however, did not experience any decrease in the intensity of her pain after terminating her working life\(^ {36}\).
As mentioned in the previous section, fifteen participants in this study state in the questionnaire that they have histories of pain episodes that date back at least six months prior to the time of the interview. Pain lasting for months or years, however, does not indicate that a particular pain has been persistent throughout that time. Long-lasting pain may subside and return as well as vary in intensity. Even though participants state that their pain has lasted for a long period of time, this does not mean that their pain has been persistent throughout a given period. Musculoskeletal pain rather seems to fluctuate and vary in intensity regardless of whether it is reported as a long-term or short-term pain.

This section has established that the prime source of knowledge of musculoskeletal pain is a sensory feeling in the body. The participants’ labels for their pain are examples of creative metaphoric language. Participants used these metaphors to distinguish between the intensity and quality of different kinds of pain. The metaphoric labels for pain may illustrate some quality of a particular pain residing in the body but they may not adequately describe the intensity of a particular pain or episode of pain. As the previous sections have proven, pain is experienced as varying in intensity within an episode over time within a certain area of the body.
Pain may be experienced as slumbering in a particular area of the body in order to be activated slowly, or it may strike from without – for example, the “witch-punch”.

Although the body is the prime source of the participants’ knowledge of pain, their expressions of the sensory manifestations of pain show that there are other sources of pain shaping their knowledge of pain. Knowledge of pain is inherent in biomedical as well as lay etiology. Other sources of knowledge are the media, whose stories of pain cast doubt, hope or fear into the experience of episodes of pain and would-be episodes. Indeed, pain seems to run in communicative sensory channels within the boundaries of the body as well as in a communicative exchange with the social world at large.

5. Consequences of musculoskeletal pain

Approximately half of the participants in this study give an account of some of the consequences of their pain. The other half does not evaluate their complaint negatively, either because the complaint is minor, or because they go about their daily lives without thinking or talking much about it. In this section, I discuss other reasons why some participants do not discuss the consequences of their complaints.
Accounts of the consequences of musculoskeletal complaint are categorized as reduced physical activity, refraining from socializing and early retirement or disability pension.

**Reduction of physical activity**

Being in pain may reduce levels of activity permanently or in certain situations. It may cause the inflicted to be unable to grab a pen, to have to sit down while dressing, to be unable to find an adequate working position and/or to have to restrain from doing sports formerly enjoyed. Musculoskeletal pain may also lead to headaches and especially tiredness and exhaustion. Tiredness and exhaustion as a result of pain is described as rather incapacitating, since it forces the inflicted to slow down or abstain from carrying out desired tasks or activities.

**Refraining from socializing**

The exhaustion caused by pain may lead the inflicted to withdraw from social life. A common way of keeping up social relations in Danish society is by throwing dinner parties and going out for dinner parties at friends’ homes. Managing pain in daily life may demand so much attention that the inflicted turns down invitations to socialize. Those whose social life outside their family has consisted in more or less
excessive sports activities find that they are excluded from these communities. At least one participant indicated that this could actually lead to his social demise, since he had taken up gambling and drinking to replace the sports he could no longer do because of his knee damage. 

_Early retirement and disability pension_

Early retirement and disability pension constitute the most explicit kind of marginalization resulting from incapacitating pain seen in this study. Two participants who worked as sewing machine operators in the textile industry have experienced this. Both participants regret their exclusion from the labour market. One rejected the option of seeking economic compensation for her occupational disability on the grounds that she felt “at fault” for becoming ill. The other was advised to seek disability pension, which caused her to feel “pushed out” of the labour market. She regretted that nothing had been done, in her opinion, to place her in a different, suitable job. These two participants clearly felt uneasy about being provided for by public funds and they felt themselves placed at the margins of society.

In sections 4 and 5 I have presented the participants’ knowledge of the
consequences of their pain as well as their knowledge of the sensory experience of pain. Knowledge of the consequences of pain and of how it manifests itself in the body cannot, however, be fully understood without exploring the participants’ reflections on the origins of pain.

6. Origins of pain

The onset of pain and basis for complaints in social contexts is included in the term origin. The participants’ knowledge about the situational as well as biographical context of musculoskeletal pain uncovers historical as well as situational contexts of pain in their life. In short, origin refers to the complex of conditions of musculoskeletal pain according to the participants’ accounts.

*Mystery or media?*

Even though some participants give an account of events which can they relate to their complaint, they do not always see the event as adequately explaining their pain episodes in everyday life. Stories of injuries related to computer work as well as popular accounts of somatization called “life-ache” nourish speculations on the origins of their pain that run counter to their own experience of particular pain-related events. For example, one female participant was quite mystified by a pain
that came and went in her left arm, the right arm being the one she used for computer work. Her reflections on her complaint were indeed nourished by what she learned in the media: “There are so many stories about us working with computers ... it [pain in her arm] may show up from one day to the next. Suddenly something just happens”\(^40\).

Accounts of the mystery of pain do not exclude accounts of other sources of origin. Participants typically search in a wide range of contexts for the origin of their pain. All participants formulate and reformulate the origins of their pain, which are located in the context of their families and jobs.

\[Speed and the whip – working life\]

Elderly participants describe their pain as originating in the continuous or repetitive hard physical labour they carried out since childhood. A cleaning woman, a sewing machine operator and an unskilled labourer started their working career as children or teenagers. One woman tells about working as a child on the farm where she grew up: “When we were children we collected stones [in the fields]. A bag was tied around our waists to collect the stones in. Try to imagine small children doing that... what that does to their backs”\(^41\). A sewing machine operator who worked
almost a lifetime as a pieceworker proudly tells how she liked to compete with her colleagues and for years was the fastest operator in the factory, yet she ascribes her current pain to those very same working conditions. Being “worn” from work is a common expression used by elderly participants who were engaged in hard physical labour starting in childhood – for example: “I suppose it’s because I’m worn. I haven’t spared myself. And I have never been spared either. I was just told to work. There was no authorized inspection of working conditions then”.

A man who did over forty years of manual labour ascribes the pain in his shoulder and arm to the monotony of hard labour: “Because it is monotonous work, the same again and again, back and forth. It is simply wear and tear. Even when I was sixteen-seventeen years old I began seeing the local healer because I had back pain”. The continuity of pain originating in physical work over a lifetime is irreversible and not easily spoken about. Short sentences may however accurately express the experience: “I’ve been under the whip since I was fourteen. Nothing can change that”. The strain of the physical workload for the elderly participants refers not only to the continuity of the strain over time, but also to the intensification of strain because the time available for essential tasks was gradually reduced. This is the case in the service and health care sectors, where participants
express discontent with their working conditions, in particular the time schedules and cutbacks on personnel\textsuperscript{45}. Elderly participants are not the only ones who ascribe their pain to hard and repetitive physical labour; also participants in their twenties and thirties ascribe their complaints to hard and/or repetitive work. It may be the baker or the mechanic who works in awkward positions or the groom who simply experiences how hard it is to ride, feed and care for horses many hours a day.

Pain may be ascribed to sedentary working life. A salesman who travels in a car most of his working hours is certain that his “back troubles” originate in the fact that he is sits in his car all day, and since he travels long distances abroad he does not seem to find the opportunity to exercise. As he states: “life is like a freeway ”, which expresses his fast-paced yet sedentary working life\textsuperscript{46}. Sedentary working life does not explain the origin of pain, but physical inactivity itself is often described as aggravating an already existing complaint. Stressful physical activity followed by periods of rest is also experienced as causing pain when the period of rest is over. Being in poor physical shape or exercising incorrectly is also a common explanation for the origin of aches and pains.

A generally high level of activity in the working life of certain participants as well
as in their social and family life is also explained as an origin of pain. The use of
the term “stress” is a common denominator for a high level of activity. One aspect
of “stress” is being overloaded with responsibility with or without backing from
colleagues and family. Both men and women explain pain as a result of stress. A
male schoolteacher even sees pain as an outlet for the pressures of daily life: “I
really think that one [the pain] is psychologically determined ... it was when there
was pressure [concerning daily tasks], then my neck stiffened”.47 Last but not least,
pain is also explained as originating from sports activities on a playing field – for
example, sliding on wet turf and playing sports games without prior warm-up48.

Worries

The female participants often ascribe their pain to the burden of coping with
troublesome social situations or troublesome social conditions in their working
and/or family life. A young female participant is convinced that her back pain
originates in her worries about schoolwork combined with troubled social
relationships because she was mocked for years in school49. To be concerned about
the well-being – especially social failure or the impending social failure – of family
members or friends is also explained as a cause of pain in muscles and limbs. When
pain is explained as originating in social disturbances it is reified, “lodging” in
muscles and/or limbs: “I think it simply comes from being mocked in school. It simply lodged in my back”\textsuperscript{50} and: “Worries. Some of them are in my knee”\textsuperscript{51}. One woman attributes her pain to her concern about other people’s troubles: “If somebody gets something off their chest … a grief or something. They walk away relieved, but I catch something”\textsuperscript{52}.

Reflections such as these made by certain participants on the origins of pain suggest that women experience musculoskeletal complaints as a result of imbalances in personal relationships and social interaction. This does not mean that this does not apply to any of the male participants in this study. However, only one male express the relationship between pain and social interaction as explicitly as do the female participants.

\textit{Inheritance}

Some participants refer to pain as an inherited trait. A female participant makes the following remark about her mother: “My mother has always had a sore back. I have always listened to her talking about how she could hardly get out of bed and how she can hardly get up from a chair because of that back of hers. So when that pain is there you can’t help thinking: I wonder if I won’t be able to get up one day”\textsuperscript{53}. I
classify this example under the category of inheritance because of the particant’s preoccupation with comparing her own pain to that of her mother’s in her search for an explanation as well as in her evaluation the future course of her pain problem.

Pain is also explained as originating in a particular physiognomic constitution: “It’s simply because my back is a little weak”\(^5^4\) or “My doctor said it [her work as a sewing machine operator] ruined my neck and shoulder. But I thought it was because of my breasts. I simply had large breasts. And I had them operated, to see if that would help, but it didn’t”\(^5^5\). A young man thought his pain stemmed from an inherited weakness in his knees: “Perhaps having knee pain runs in the family”.\(^5^6\)

Three aspects of inheritance seem evident: physical constitution, how pain is perceived and the social conditions that determine musculoskeletal pain such as hard manual labour and relative poverty, aspects that may in reality be blended. Perceiving pain as inherited seems to leave the inflicted helpless to rid herself from what seemingly “runs in the family”. Participants may however attempt to compensate for inherited physical traits that can cause pain by modulating their body or by physical exercise or cosmetic surgery.
In this section I have shown that knowledge or the search for knowledge of the origin of pain touches on the vulnerable issues of identity and existence. It involves reflecting on the life one has led so far, which includes reflecting on the pain as a reminder of something that has gone or may have gone wrong in life. Thus pain does not only disturb the body, it also disturbs the social and moral order of existence, whether the disturbance is experienced as minor or major. The sources of knowledge of the origin of pain may be located in the biographical contexts of their life history or in reflections on daily life around the time of the interview.

7. Dealing with pain in the folk sector

Exploring participants’ knowledge of how to deal with their complaints in the folk sector involves an investigation of the caring and coping strategies used in the participants’ intimate spheres of life, i.e., in their family and other close relationships. All the participants state that most episodes of pain are dealt with in the intimate spheres of life, since it is not considered worthwhile to go to professional caregivers to discuss the pain. Participants give two reasons for this: one is that many episodes of pain are considered minor and transitory; the other is that previous visits to medical doctors have proved fruitless. In those cases they
have given up their hopes for a cure or total relief from pain and settled on occasional relief. On the social level of coping with pain, the participants describe different strategies that are meant to balance the demands they experience on their role performance and their wish to take care of their bodily needs.

**Body techniques**

The category of 'body techniques' refers to a wide range of knowledge and activities that the participants use in order to alleviate prevent and cure their musculoskeletal pain. On an individual level these techniques reflect initiative and creativity on the part of the inflicted to overcome their pain. These techniques are self-taught, thus equipping the inflicted with particular competence or practical knowledge. On a societal level, however, these techniques reflect the values of the wider society in which the participants are a part.

*Shifting body positions and ergonomics:* Some may find relief in constant movement since resting positions or physical inactivity enhances pain\(^57\). Changing body positions in working situations or other contexts may however be in conflict with the desired relief from pain, since the change itself may lead to another localized pain. Altered body postures may physically strain the body. Changing
working styles by getting new equipment such as ergonomic chairs, tables or footwear is an example of a change desired in the workplace that may compensate for the impairment caused by pain.

*Tempo:* One participant reports that her employer demands speed and discipline on the job. To counter the pressure from her employer this participant paces her duties when working alone: “I continue [working] but at a slower pace. I slow down if I feel that there is something wrong [a pain episode coming up]. I actually take it into consideration. I know if I don’t do that it may go completely wrong. But sometimes it’s difficult. I feel better when I’m working on my own because then I can set the tempo. I decide what tasks to do, how I should do them and in which order”58.

*Reading body signals:* When describing how they alleviate or prevent pain participants talk about “listening to body signals”.59 By this they mean a learning process of reading the signs of bodily sensations of pain and interpreting them as meaningful in terms of actions worth taking to alleviate or prevent pain. The strategy of reading body signals is based on the moral grounds that each individual is responsible for maintaining a healthy and thereby pain-free lifestyle, as well as on a fear of future episodes of pain, which encourages the inflicted to seek to
prevent pain by reading signals early on.

*Physical exercise and massage.* Some of the participants state that they do physical exercises at home that they have invented themselves or learned from either professional health care professionals or sports instructors. Doing sports or other forms of physical manipulation is also mentioned as a strategy to prevent pain. Massage by family members as well as self-massage is used to ease tense muscles.

When the interviews centered on issues of preventive action like sports and physical exercise they talked a good deal about their feelings of guilt and self-blame. Participants blamed themselves for not taking enough action. Self-blame and guilt is just as frequent among participants with minor experiences of pain as among participants with major pain episodes. It is a common notion that physical exercise is paramount to a healthy self, a body free from pain. It is ironic that self-blame in the area of sports and exercise exists despite the fact that the pain experienced by some participants is the result of sports activities.

*Applying remedies.* In order to alleviate pain it is common for the participants to
use over-the-counter painkillers from the local pharmacy. Applying Japanese peppermint oil to aching muscles or placing a kind of magnetic plate on aching body parts are also mentioned. The magnetic plates are either recommended by other friends or bought on the basis of advertisements in magazines or newspapers.

Talking about pain and health. Talking about pain reveals several aspects of the ambiguity of bringing pain from the private to the public sphere of life. Talking about pain with a physiotherapist, a family member or a colleague may be experienced as an effective way of dealing with it, a way to help keep spirits up and to receive tips about techniques to relieve or prevent pain.

The younger participants in this study are more likely to follow the current trend of talking about life events with friends or professionals. This trend stands out against the stoicism or ‘passing’ strategies of the elderly participants and participants who regard their pain as too private to talk about. Participants generally found it quite difficult to put their experience of pain into words, but on the other hand they also found it liberating, especially those inflicted with long-term and/or intense pain.

On the other hand, talking about pain is also perceived as a negative action because
it is interpreted as complaining and considered socially undesirable, possibly contributing to greater pain. The participants with this attitude are in favor of bearing the pain without flinching. Stoicism thus seems to overlap with ‘passing’ to avoid socially undesirable behavior.

It may not be considered worthwhile to talk about pain because it is too faint to make a fuss about or because talking about pain would disturb social networks and family life. One participant explains it this way: “You cannot complain every day, so I don’t. Both of us [ID: 218 and his wife] have little defects, but you can’t talk about them every day. It’s not like I can’t live with it. Evidently something will occur through a lifetime, and I don’t think I’m worse off than others.” Stoicism and the endurance of pain are found in men and women equally among the middle-aged and elderly participants.

*Praying and deep relaxation.* One participant mentions praying as a very effective way of relieving pain. In this case the participant’s experience of having access to what she herself regarded as protection from a spiritual resource was not limited to an affiliation to a particular religion; it was rather an influence of the New Age movement strategies of deep relaxation, techniques of accessing spiritual resources
as well as an interpretation of pain as originating in situational, social and biographical imbalances. This participant had come to feel overloaded with responsibility in her working life. After a series of cutbacks in her department she no longer had the support of her colleagues; instead she drew extensively on the help she could obtain through praying. She also interpreted the musculoskeletal complaints of her colleagues as the result of imbalances in their working and social lives.

The management of pain in the folk sector shows that participants posses a wide variety of knowledge of how to alleviate pain as well as of how to prevent future episodes of pain. A multitude of body techniques used in daily life shows the entrepreneurial aspect of those inflicted with pain.

8. Dealing with pain in the professional sector

The practitioners mentioned by participants are generally medical practitioners, physiotherapists and chiropractors. The participants rarely consult their medical practitioner, since they do not expect a cure, although they may have had higher hopes for a cure at an earlier stage. Some participants may however consult their general practitioner in order to receive treatment with prescription painkillers or to
get a referral for other specialist treatment. The types of treatment used in the professional sector and the evaluation of this are related to issues of compliance, as shown in the following section.

Type of treatment and evaluated effect

Physiotherapist and chiropractors: Chiropractors and physiotherapists are valued for their expertise in alleviating pain. The participants generally assign a positive value to training the body with a physiotherapist in a team and learning work-place ergonomics. One participant is so enthusiastic about this kind of training that he teaches it informally to colleagues whenever the opportunity arises\textsuperscript{72}. Another participant, however, evaluates the effect of treatment by a physiotherapist rather negatively, since a specific training programme that he had followed worsened his damaged knee\textsuperscript{73}. Several participants mention using prescribed orthopedic footwear and corsets but do not evaluate their effects.

Medical doctors: The sports doctors mentioned are positively evaluated for their ability to alleviate pain. However, the participants evaluated other medical doctors neutrally or negatively. Medical practitioners are mainly used for prescribing painkillers, and in cases of incapacitating pain the inflicted go to medical
specialists, who determine whether they qualify for disability pensions.

It is striking that two participants who reported that they had been advised by medical practitioners to seek compensation and disability pension on the grounds of their work had quite negative thoughts about this. One woman now receiving a disability pension felt that she had been pushed out of employment permanently since in her opinion no effort had been made by specialists to place her in a less strenuous job. She also felt strongly that she was at “fault” herself for seeking jobs that were physically damaging and that she might have been able to provide for herself in other types of jobs if given the chance\textsuperscript{74}. The other participant, who described her pain as rather incapacitating in her daily life, had rejected the advice of a medical practitioner to seek compensation and disability pension, since in her opinion the negative effect of her work on her health was her own “fault”. During the interview, however, she expressed doubt about her decision to reject compensation and asked if it would be possible to reapply\textsuperscript{75}. 
Time and trust

One aspect of the participants’ trust in their practitioners is related to their style of communication along with the consultation length. A common complaint about the communication style of medical practitioners is that they are considered to be too quick to offer a diagnosis and prescribe medication, leading to errors and the poor treatment of their patients. One participant is quite explicit, stating that practitioners ought to be given a fixed salary instead of being paid by the number of patients they see, since the latter system, in this participant’s view, encourages practitioners to rush their patients through consultations. One participant is very positive about consulting a particular physiotherapist who always makes a point of talking about body techniques and training programmes.

Knowledge and trust

Another aspect of the participants’ trust in their practitioners is related to participants’ experience of the effectiveness of the treatment they receive from their practitioner. One participant says she has lost faith in her practitioner because he has not been able to help her. Participants who have not been helped by their practitioners are not as explicit about losing faith in their practitioner but instead turn to the popular sector, acknowledging that their practitioners have not been able
to help them. Implicit distrust in practitioners is however felt by those who have experienced incompetence on the part of their practitioner, not being taken seriously or being given inaccurate information about the prognosis and treatment. A participant with incapacitating knee damage complained that the medical practitioners he saw in hospital did not seem to have any understanding of the impact his pain had on his daily life, especially on his work as a baker, which strained his knees to the limit.\footnote{80}

Trust is not only related to the experienced competence of the practitioner. Some participants are under the impression that practitioners do not always tell them everything they know. The impression that practitioners withhold information on the status and prognosis of the pain is somehow discomforting and difficult for the patient to handle since, as one participant says: “If you don’t ask questions yourself, then they [practitioners] might not tell you. And if you don’t know exactly what the problem is, then you cannot ask [the proper question]”\footnote{81}. Participants who have some hope that their practitioner will alleviate or cure their pain wish to be in agreement with their practitioner. Those participants who have given up hope of being provided with relief or a cure by their practitioner, however, do not strive to be in agreement and they may often seek help in other sectors of the health care...
Practitioners in the professional sector are considered experts and thus seen as holding power and authority. Therefore, participants generally go a long way to comply with the prescribed treatment. When or if they judge that the treatment is not worthwhile they may fear being rejected by their practitioners. One participant expressed fear about rejecting the treatment offered in hospital on the grounds that he would be rejected universally by “the system” even though he considered the treatment completely useless and risked suffering from severe side effects\textsuperscript{82}.

The practice of managing musculoskeletal pain in the professional sector is characterized with the participant’s hope and enthusiasm as well as the constraint of successful consultations and/or treatment. Trust professionals as well as the time spent on the consultation seems to be an important indicator of participants evaluation on success in treatment.
9. Dealing with pain in the popular sector

Whereas the participants feel that the professional sector is not as effective as it could be, they positively evaluate the popular sector inhabited by practitioners such as traditional hands-on healers and reflexiologists.

*Type of treatment and evaluation*

When the inflicted cannot achieve pain alleviation or episodic relief from pain in the professional sector they seek this in the popular sector from local healers, reflexiologists and masseurs and masseuses. Participants who have used such practitioners evaluate them according to their skills. Traditional healers are evaluated according to their skill in manipulating aching body parts so that they stay free of pain for months. Reflexiologists use different techniques of manipulation but are evaluated equally positively by participants who have tried this kind of treatment.

Sports and fitness centers belong in the popular sector, where participants go to deal with their pain as well as to prevent future episodes of pain. Some participants mention that they occasionally pay for a massage in such centers as a strategy to overcome muscle tension, while training in fitness centers is
mentioned as a means to build strength in muscles and limbs, which some may do to comply with recommendations made by their physiotherapists.

**Efficacy and trust**

The participants’ positive evaluation of the popular sector demonstrates their relatively high degree of trust in it. Participants who have consulted practitioners in the popular sector said that these practitioners refer their patients to the professional sector if they think that a consultation and treatment there would be more appropriate. Participants who had been skeptical of such “quack”-like treatment before turning to it became optimistic after a few treatments. For instance, one participant stated, “I never believed in such quackery. But now I respect her, I really do”, and another said, “Perhaps you need two or three treatments before you can feel the results. But the thing in my neck – he says he can’t do anything about it. (...) But if something has jammed, a nerve has jammed, he can help you, definitely”.

The positive evaluation of the popular sector seems to be based on the knowledge that such practitioners are more effective in providing relief than medical doctors. Another criterion for this positive evaluation is that relief without medication is
offered in this sector. Participants who have experience with practitioners in the popular sector regret that access to such treatment is limited by the practitioners’ fees, which are often considered too costly since this kind of practitioner is not supported by the government as the professional sector is.

10. On being interviewed about musculoskeletal pain

The lay knowledge accessed and explored in this study belongs to the world of undiscussed or undisputed experience – it is silent and doxic knowledge (Bourdieu 1977: 168). Understanding the self-evident and matter-of-course presuppositions of bodily knowledge requires paying attention to this kind of knowledge that flows from practical sense (Bourdieu 1990: 68). The specific nature of that knowledge partly explains why the participants and the interviewer experienced accessing and explicating this knowledge as a major challenge. Another explanation for this is that pain was regarded as too private to expose in front of an unfamiliar interviewer.

Consequently, some participants found it exhausting to answer persistent questions about their complaint[^88]. This was expressed verbally or interpreted by the interviewer based on the appearance and actions of the participant (lack of eye
contact and sighs). One participant clearly stated that she wished the interview would soon be over\textsuperscript{89}. She did not find her “case interesting” and said that she thought other people with more severe complaints would be more interesting to interview and help.

Not only was a language for the doxic knowledge of pain invented during the interview, but the interview also created time to reflect on the broader issues of life and musculoskeletal pain, which was new for at least one participant\textsuperscript{90}. Others were just pleased by the liberating and relaxing effect of the interview\textsuperscript{91}. One participant expresses this metaphorically as “a stone has fallen from my heart”\textsuperscript{92}. Others just found it “nice” to talk about their complaints from their own perspective\textsuperscript{93}.

11. Discussion

This study has been carried out in order to search for answers to questions concerning the sources of knowledge of musculoskeletal pain, the nature of knowledge of musculoskeletal pain and the social and moral issues implicit in that knowledge. The study indicates individual as well as social dimensions of the participants’ knowledge of their musculoskeletal pain.
At the beginning of this paper I claimed that participants’ knowledge of their musculoskeletal pain could be categorized as doxic knowledge (Bourdieu 1977: 169). I also claimed in keeping with Kleinman that the participants’ knowledge of their complaints was characterized by vagueness and multiplicity (Kleinman 1980: 107-9). In being interviewed the participants have taken part in a process of objectifying their knowledge and making it more explicit; the otherwise silent knowledge has become a discourse invited and partly constructed by the anthropologist (Bourdieu 1977: 18-20).

For the participants the interview provides an opportunity to reflect on the practical knowledge they have developed while going about life with episodes of musculoskeletal pain. The practical knowledge revealed in this exploration is a variety of knowledge drawn from available sources – the body, the health care system and the media. The nature of the knowledge of musculoskeletal pain that is revealed by the participants is thus a reproduction of selected and reinterpreted knowledge drawn from a large number of sources (Bourdieu 1977: 98).

Musculoskeletal pain is experienced as sensory feelings interpreted and acted upon
in different ways. The interpretation of musculoskeletal pain shows that it is of an ambiguous nature. Musculoskeletal pain may be interpreted in rationalistic frameworks of simple cause and effect, such as falling from a scaffolding and damaging one’s lower back. But as regards participants’ experiences of how episodes of pain work in the body in everyday life, the study reveals that pain may be experienced as mystical, ongoing or transitory, as coming from outside sources or from inside the body. Pain is also expressed in metaphors with a range of active and passive qualities. Thus pain is expressed as having communicative qualities and channels within as well as without the body. Reflections on the origins of pain indicate that pain may be interpreted as an imbalance in the entire social environment, given that media, “witches” and worries may enhance or cause episodes of pain.

According to the participants’ reports that their pain originates in the strains of everyday life, pain is not only located in particular areas of the body, but also in the social environment in which individual bodies are situated. Pain is described as intersubjective and communicable, which makes it absurd to speak of clear distinctions between the causes and effects of pain according to the practical knowledge of participants. It seems that pain is also mediated between the inner
and outer worlds of bodily and social experience. Folk-etiologic categories such as “stress”, “pressure” and “witch punch” may be regarded as manifestations of imbalances in the social fabric of everyday life in the form of individual pain. Thus, musculoskeletal pain is not only based on physical disruption, but also on social disruption.

Musculoskeletal pain is dealt with in a variety of ways, mostly invented by the individual through experiments with different body techniques in order to ease or alleviate episodes of pain. Changing one’s body positions in work situations and one’s work tempo and paying attention to and interpreting sensations of pain are all learned and developed in going about daily chores. By interpreting bodily sensations and acting on these interpretations, the inflicted exercise practical mastery, thus becoming experts in their own right in dealing with their pain (Bourdieu 1977: 88).

Adopting what Bourdieu calls “structural exercises” – pacing one’s work, doing gymnastic exercises, talking to someone and/or praying – participants perform rituals of everyday life in both private and public spaces. These practices are all manipulations of bodily experience, which tend to integrate the body with social
and in some cases even cosmic space (Ibid: 91). Dealing with pain in this way, the participants access all available sources of aid in order to remain integrated in society, where they assume their roles as knowing subjects (Ibid: 2).

The doxic knowledge represented in this study is not only knowledge that shows individual variation and creativity in dealing with everyday pain; it is also knowledge, which shows social connections and constraints in handling musculoskeletal pain (Barth 1993: 173; 1995: 66-67). The knowledge that the participants possess about their pain – how it manifests itself, its origin(s), treatment and prevention strategies – is knowledge that reflects wider social issues of body, health and society.

**Risk and blame**

Risk is a central cultural and political category that has become more and more widespread as an organizing principle for human existence. Risk is perceived as something that may be manipulated by human intervention and as such risk is related to ideas about choice, responsibility and blame (Lupton 1999: 24). In this study, musculoskeletal pain is treated as knowledge of lived situational and biographical experience with everyday pain and the experience of pain as an
interpretive reality of commonsense meanings and knowledge (Lupton 1999: 27). The knowledge of musculoskeletal pain revealed here contains reflections on the risks, which involves the issue of blame.

Attitudes to risk vary because they depend on which areas in life are regarded as 'fixed' and 'inevitable' or on whether these areas are subject to human agency (Lupton 1999: 107). In this study it has become clear that pain may be related to one or more events on which participants have no direct influence – for instance, working conditions and sports accidents – and therefore they regard their musculoskeletal pain as an inevitable part of living. This does not mean that participants are not concerned with issues of individual responsibility.

The participants in this study are part of a society that increasingly individualizes the responsibility for maintaining a healthy body. They talk about their own responsibility and how they see their own actions as part of their problem and its possible solutions. The issue, however, is ambiguous. On the one hand, they see themselves as free agents of their life, with free choices; on the other, they are subject to internalized demands of self-control. They see themselves as responsible for their health and yet also dependent on certain conditions – for example,
occupational ones on which they had or have no influence (Beck and Beck-Gernsheim 1995: 7 in Lupton 1999: 70).

A body free of symptoms and sickness is imperative to a modern healthy self. In this study, several participants across age and sex groups were more or less preoccupied throughout the interview with thoughts on the sources of their pain, what they do and especially what they feel they ought to do about it. A preoccupation with individual responsibility is linked to self-blame and risk management. Thoughts about “not doing anything” to prevent future pain episodes or adjusting circumstances in daily life give rise to self-critical attitudes about not caring adequately for one’s body. Going to fitness centers and shaping one’s body in order to keep strong and healthy is regarded as “doing something”, whereas resting on the couch after a long working day is regarded as “doing nothing”.

Passing

Knowledge of musculoskeletal pain touches on issues of identity and being-in-the-world for those inflicted, because pain is a reminder that something has gone wrong or may go wrong in one’s life and therefore a threat to performing in life. Since health has become imperative to modern life there is little prestige in sick roles.
According to this study, it is evident that musculoskeletal pain is performed according to an imperative of health. The participants in this study exhibit different strategies for performing pain that may be classified as ‘passing’, a term coined by Erving Goffman in his theory of stigma, which he characterizes as a learning process whereby individuals learns about themselves with respect to normality and deviance (Goffman 1963: 101).

Individuals bearing a visible or invisible stigma like pain and/or disease are persons with reduced life chances who are expected to bear their stigma – a sign of deviance and disgrace (Goffman 1963: 15). Stigmatized individuals are people who compensate for their stigma by devoting much private effort to correcting their condition through, for instance, exercise or devoting time to pain relief and/or strategies for pain prevention (Goffman 1963: 20). Stigma also implies the secondary gain of being excused from particular social and/or practical activities. This study shows that strategies may be performed in the intimate spheres of family life or they may be performed in the more public spheres of life such as the fitness center. For the individual one area of performance does not exclude the other.

The stoicism of the everyday management of pain may be interpreted as ’passing’
in order to maintain respect in one’s family and/or community life and appear within the limits of normality and health. Engaging oneself in excessive pain-relief efforts in order to keep up with demands on role performance is also a passing strategy. People inflicted with musculoskeletal pain may become discredited or are already discredited; they handle their risks by dividing the world into a large group that they tell nothing and a small group that they tell everything and on which they then rely for help (Goffman 1963: 117). Talking about pain and health to, for example, one’s physiotherapist or reflexiologist is part of the control of information that characterizes passing.

In the light of this discussion it seems reasonable to suggest that the participants who did not give an account of the consequences of their pain did not want to talk about it in the interview because they followed a ‘passing strategy’ of coping with pain and/or a strategy that involved bearing the pain without flinching – stoicism. Passing also involves diverting one’s own and others’ attention from the pain by taking an interest in activities like gardening or housework. Participants explain this as a strategy to distract their mind from the pain, but it may also be interpreted as a mechanism allowing the inflicted to ‘pass’ the pain by keeping an activity level appropriate to their social role.
Counter to these observations on passing is the evidence that younger participants are more open and talkative about their complaints, which they are less likely to regard as private. While the elderly participants base their authority in dealing with pain on a private level, younger participants base their authority in dealing with pain in open discussions with friends as well as professionals.

**Authority**

Musculoskeletal pain may lead to situations in which the everyday order is challenged and with it the situations that call for extraordinary action. Once a “private” experience of musculoskeletal pain is taken into the public spheres of the popular and professional health care sectors this experience undergoes a change of state (Bourdieu 1977: 168). When brought to the medical doctor or local healer the knowledge of the inflicted passes from the universe of the undiscussed and undisputed to the universe of discourse or argument (Bourdieu 1977: 168).

The participants’ evaluations of their treatment clearly show that matters of authority are at stake. When consulting a practitioner on the grounds of musculoskeletal complaints patients are hoping for relief, a cure and
comprehensible information. They expect to be confronted with professional authority. The ideal is that the quality of the practitioner inspires confidence and is exercised in the form of a protective authority based on the trust, which the patient has in the practitioner (Bourdieu 1977: 192-193). Not surprisingly, participants who invest great trust and authority in their practitioners exhibit compliance with the practitioners’ advice and treatment. In one instance this is at the expense of health. Participants with experience of the popular sector seem to find more relief and comprehensible information here than in the professional sector. Practitioners in the popular sector therefore appear closer to the ideal of what Bourdieu terms ‘protective authority’ (Ibid: 193).

Practitioners in the professional sector open the gates to social welfare on the basis of diagnostic criteria interpreted by the practitioner and his medical institution. It is therefore ironic that participants who have been granted social welfare benefits or advised to seek them on the grounds of occupational disability were critical of their practitioners. They saw their medical doctors not only as protectors, but also as negative authorities that had led them into a marginalized state in their social life.

Medical practitioners are generally regarded as figures possessing authoritative
knowledge, knowledge that differs from the practical knowledge of the patient. Judging from participants’ accounts, the two types of knowledge are seldom exchanged between medical doctors and their patients. Lay knowledge and expert knowledge may not be communicated in the brief consultations where there is no time for comprehensible medical explanations of what is going on in the body. In the popular sector and in some instances with physiotherapists in the professional sector, the participants seem more likely to be involved in a transaction of knowledge between themselves and the practitioner, with the knowledge of the client being recognized and turned into a comprehensible discourse for the patient and/or used to achieve effective treatment.

12. Conclusion

The experience of pain is a challenge to human and bodily creativity in the search for ways to overcome and/or minimize pain. This exploration has placed emphasis on the practical knowledge of persons with various degrees of musculoskeletal pain. The practical knowledge of participants is replete with documentation of the ambiguous nature of pain on a physical as well as a social level.

Knowledge of pain is derived from a multitude of sources such as the body, the
media and the health care system. According to this investigation it becomes clear that pain must be viewed not only as a phenomenon residing in the body; pain is experienced as communicative within the boundaries of the body and in an exchange with the social world.

The individual is involved in a relationship with his or her social environment and it is this exchange which shapes the practical knowledge of pain. In this exploration it has become clear that the participants manage pain actively and creatively, adopting individual strategies for relieving and preventing episodes of pain. The practical knowledge also shows that this creativity is met by social and cultural constraints such as blaming, passing and the negative effects of relations of authority in the interaction between patient and practitioner. Younger participants are however more likely to deal with their pain in the open and “responsible” style prescribed by the healthism of modern society. It remains an open question, however, if the active style of younger participants results in better health outcomes compared to those who ‘pass’ their complaints or keep them silent according to a strategy of stoicism.
Literature:


Notes:

1 Transl. from *den*.
2 ID: 483. Transl. from: *heksestød*.
3 ID: 67; 115; 118; 128; 403; 474; 520; 944. Transl. from: *ømhed*.
4 ID: 115. Transl. from: *muskelinfiltrationer*.
5 ID: 183; 391; 893. Transl. from: *rygproblemer*.
6 ID: 520. Transl. from: *kold skulder*.
7 ID: 520. Transl. from: *golfarm*.
8 ID: 520. Transl.: *sølle led*.
9 ID: 115; 172; 520; 602. Transl. form: *ledegigt*.
10 ID: 67; 160; 218; 602. Transl. from: *iskias*.
11 ID: 160; 149. Transl. from: *diskusprolaps*.
12 ID: 128. Transl. from: *allergi*.
13 ID 520. Transl. from: *forkalkning af leddene*.
15 ID: 67; 115; 118; 128; 474; 483; 944. Transl. from: *øm*.
16 ID: 67; 115; 118; 128; 160; 172; 183; 218; 391; 411; 474; 483; 490; 520; 584; 602; 658; 893; 944. Transl from.: *det gør ondt*.
17 ID: 218; 483. Transl. from: *jagende*.
18 ID: 115; 172; 483; 520; 944. Transl. from: *sovende fornemmelse*.
19 ID: 160. Transl. from: *lang rund ting i ryggen - lige som is*.
20 ID: 128; 172; 183; 944. Transl. from: *stik*.
21 ID: 602. Transl. from: *følelse af uro*.
22 ID: 67; 118; 183; 218; 391; 474; 483; 602. Transl. from: *stivhed*.
23 ID: 67; 118; 160; 172; 474; 658. Transl. from: *spænding i musklerne*.
24 ID: 118; 160; 172; 658. Transl. from: *hårdhed i musklerne*.
25 ID: 115.
26 ID: 67; 128; 172; 326; 474. Transl. from: *knæk i leddene*.
27 ID: 128; 944. Transl. from: *brændende fornemmelse*.
28 ID: 118; 944. Transl. from: *murren*.
29 ID: 893. Transl. from: *Det føles som om der er nogen der drejer knive rundt i dit knæ*.
30 ID: 67. Transl. from: *stråler ud i balderne*.
31 ID: 115. Transl. from: *Eftersom som der er så mange muskler så kan smerten være ganske forfærdelig i din krop. Og da musklerne ikke bor alene, de er forbundet alle sammen, problemet kan være opstået et andet sted end der hvor smerten er*.
32 ID: 67; 115; 529.
33 ID: 520. Transl. from: *der går ikke en eneste dag, hvor jeg ikke har smener*.
34 ID: 602. Transl. from: *kommer i ture*.
35 ID: 172.
36 ID: 520.
38 ID: 893.
39 ID: 490, 520.
40 ID: 483. Transl. from: *Der er så mange historier om os der arbejder med computere ... en skønne dag ... det [smerte i armen] kan komme fra den en dag til den anden. Pludselig sker der noget*.
41 ID: 115. Transl. from: *Da vi var børn samlede vi sten [i markerne]. Vi fik en sæl bundet rundt om livet til at samle stenene i. Prøv at forestille dig små børn gøre det ... hvad det gør ved deres ryg*. 

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Jeg går ud fra det er fordi jeg er slidt. Jeg har ikke skånet mig selv. Og jeg er heller ikke blevet skånet. Jeg blev bare sat til at arbejde. Der var ikke noget arbejdstilsyn den gang.

Fordi det er ensidigt arbejde, det samme og det samme, fem og tilbage. Det er simpelthen slitage. Allerede da jeg var 16-17 år gammel begyndte jeg at komme hos en lokal healer fordi jeg havde smerter i nakken.

Jeg har haft pisken siden jeg var 14. Det er der ikke noget der kan ænde.

Livet er som en motorvej - det går bare derud af.

Den der [smerten] tror jeg virkelig er psykisk betinget ... det var da der var meget pres på [i daglige opgaver] - så stivnede min nakke.

Jeg tror simpelthen det stammer fra den gang jeg blev mobbet i skolen. Det satte sig simpelthen i ryggen.

Bekymringer. Nogen af dem sidder i mit knæ.

Måske ligger det til familien at have ondt i knæene.

Du kan ikke beklage dig hver dag, så det gør jeg ikke. Vi har begge to [ID 218 og dennes hustru] små defekter, men man kan ikke tale om det hver dag. Det er ikke sådan at jeg ikke kan leve med det. Der vil altid støde noget til i løbet af livet. Og jeg tror ikke jeg har det være end andre.
Hvis du ikke ved hvad du skal spørge om, så fortæller de [lægerne] dig ikke noget. Og hvis du ikke ved præcis hvad det drejer sig om så kan du ikke spørge [stille det rigtige spørgsmål].

Jeg har aldrig troet på den slags kvaksalveri. Men nu respekterer jeg hende. Et gør jeg virkelig.

Måske skal man have en to, tre behandlinger før man kan mærke et resultat. Men det der i min nakke - han siger han ikke kan gøre noget ved det. Men hvis der er noget der har sat sig fast, en nerve der er blevet klemt, så kan han hjælpe dig, helt sikkert.