Stories of Pain and the Problem of AIDS Prevention: Injection Drug Withdrawal and Its Effect on Risk Behavior

This study shows that drug withdrawal can be interpreted as a chronic pain condition that bridges the physical and emotional experiences of pain, especially regarding feelings of rejection, shame, inadequacy, and isolation. The experience of withdrawal among drug users, both in treatment and actively using drugs, in a predominantly working-class, industrial Massachusetts city of 185,000 was studied through questionnaires, interviews, and ethnographic observation. The results suggest that the physical effects of drug use need to be explored as a symptom of a more extensive chronic condition in which pain is both the reason for and the consequence of drug addiction. This pain condition makes avoiding needle sharing and cleaning injection equipment with bleach difficult for many drug users because tolerance of withdrawal symptoms requires tolerating not only physical symptoms but also a more complex constellation of symptoms. This research suggests that AIDS education may need to address the notion of drug withdrawal and its effect on risk-taking behavior. [injection drug withdrawal, chronic pain, HIV transmission]

Introduction

Nothing comes into your head except that you can’t concentrate on anything else. The whole time that you are sick, you’re just thinking about getting more. If you’re in jail and know that there’s no chance of getting dope, it was just trying to get some sleep or relief—escape from the anxiety and the pain. I’d take a hot shower, a sugar fix, but it’s just constant. It just makes you crazy. Now, on the streets you can do something about it, and you will do anything, no matter how bizarre it is, to make sure you’re not sick.
Most injection drug users admit that they are more inclined to take risks during times of acute need to relieve the symptoms of drug withdrawal than at other times.1 Their compulsion to escape the pain of withdrawal increases the risk of arrest and physical danger, as well as the risk of HIV transmission. Even when bleach is available to clean drug paraphernalia, the urgency to escape the pain often precludes taking the steps necessary to avoid HIV infection. An unexplored dimension of the AIDS epidemic among injection drug users is the crucial role that withdrawal symptoms play in an addict’s decision to use or not use bleach, to seek out a “clean” needle or share a “dirty” one.

My interest in conducting research on drug withdrawal developed after eight months of work as an ethnographer and AIDS educator among active and recovering injection drug users. Again and again I heard stories about the difficulties of taking precautions to avoid HIV infection while “sick” (withdrawing from heroin) or “crashing” (withdrawing from cocaine). These stories brought me to consider withdrawal and the anticipation of withdrawal as a potential barrier to behavior change that was being overlooked in the ongoing efforts to reduce AIDS-related risks among injection drug users.

This article explores the nature of withdrawal, its somatic and psychological dimensions, its personal and subcultural meaning, and its association with HIV transmission. This research proposes that by uncovering the emotional realm of drug withdrawal, withdrawal can be analyzed as a chronic pain condition. I argue that drug users experience a chronic pain condition, which becomes a barrier to both recovery and HIV prevention. The unique feature of withdrawal is that it collapses the emotional and physical realms of pain into one cataclysmic experience. I begin my argument by relating the clinical definition of chronic pain to that of drug withdrawal, and I pursue an ethnographic approach to withdrawal by using myth as a conceptual model. Through a cultural interpretation, the nature and the function of pain during withdrawal is reconceptualized. The interpretation demonstrates that withdrawal is a much more complex expression of pain than indicated in the clinical literature and that it should be considered a condition of chronic pain. The process of drug withdrawal masks and distorts cumulative emotional pain because the drug user expresses emotional pain in a way that is culturally acceptable, as physical pain. This mythologization of suffering through the physical body also gives users a sense of control over once all-consuming feelings. The results of this study indicate that pain has a profound affect on how drug users experience the world, which influences their behavior and the social support of behaviors that affect AIDS transmission. The immediacy and constancy of pain for most drug users acts as a point of solidarity, and there is a common goal among injection drug users to extinguish pain, which is most often accomplished while sharing needles. These circumstances of addiction make the task of preventing HIV among injection drug users a tremendous challenge.

Chronic Pain and Drug Addiction

The Clinical Assessment of Chronic Pain

The phenomenon known as chronic pain is problematic in clinical medicine because it lies outside of the biomedical definition of pain as a symptom of an
underlying organic condition. In addition to the pain itself being an essentially subjective experience (clinicians cannot observe it directly and no external method exists for measuring its severity [Jackson 1992; McCready et al. 1981]), the reason for the pain also eludes the medical gaze. Despite its biomedical definition as a symptom of nerve or tissue damage, it is sometimes experienced when damage is undetectable (Bates 1987; Mechanic 1972). A nonsomatic cause of pain is usually considered only subsequent to a failed diagnosis for pathology (Boissevain and McCain 1991). At this juncture in the search for the origin of pain, the pain condition is often classified as either “real” or “unreal.” Real pain is considered to be the kind of pain that has an underlying organic condition as its source. Unreal pain refers to pain for which no physical cause can be determined. Chronic pain is the most common kind of unreal pain. Pain is considered chronic when medical intervention has no success in relief of the pain symptoms, when it cannot identify a cause of the pain, or when it cannot eliminate the pain through behavior change (e.g., changing sleep, stress, or exercise patterns) (Merskey 1986). Pain from a laceration is the most obvious example of real pain in that the reason for the pain, damaged nerves and tissue, is clearly visible. Unreal pain (also termed psychogenic or psychosomatic pain) has become the common label for pain often experienced with recurrent headaches, backaches, and such specific conditions as temporomandibular joint disorder (Boissevain and McCain 1991; Good 1992). Although the definition of chronic pain varies in the medical literature, physicians commonly differentiate this pain as imagined and claim that it originates in a patient’s psychology, not the physical body.

Use of the real and unreal pain dichotomy is especially significant in regard to chronic pain because it so clearly defines the focus of clinical medicine (Jackson 1992; Moore and Dworkin 1988; Scheper-Hughes and Lock 1987). Chronic pain does not fit within the boundaries that define “normal” pain for two reasons: (1) conventional “real” pain is considered a symptom of a biological abnormality that is expected to dissipate once the malady has been successfully treated (Hilbert 1984); and (2) pain is always expected to serve a function, which legitimizes the pain experience (Jackson 1992). Chronic pain defies both biomedical and lay beliefs as to the purpose of pain. It is not a symptom of the onset of an organic condition, but is the beginning and continuation of a seemingly unending condition in which pain is the “affliction” and not the signal of an affliction (Bokan et al. 1981). As Scheper-Hughes and Lock underscore, it is the “starkly biological view” of the human condition that “categorizes human afflictions as if they were either wholly organic or wholly psychological in origin” (1987:9). This biomedical perspective extends to the clinical understanding of drug dependence and withdrawal.

The Clinical Assessment of Withdrawal

Current research on drug users takes up the basic issue of the biological manifestations of dependency. An area of little disagreement is that drug abuse creates a condition of drug dependence. Research has primarily focused on quantifying symptoms to assess their quality and intensity and addresses three main characteristics: (1) manifestations of symptoms—the physiological aches and pains, including craving, anxiety, and lethargy; (2) patterns of symptoms—the
variation and consistency in symptoms over time and severity of symptoms; and (3) the degree to which such symptoms impair normal functioning (Cohen et al. 1983; Gawin and Ellinwood 1982; Stimmel and Kreek 1983).

As in the case of chronic pain, recognition of a psychological component to drug withdrawal is entertained only in the failure to explain withdrawal as wholly physiological in nature. A scant but steady stream of psychological and medical research indicates that the psychological aspect of symptoms has a powerful effect on the withdrawal syndrome (Bradley et al. 1987; Green and Gossop 1988). According to some studies, factors such as anxiety contribute more to withdrawal severity than prewithdrawal drug dosage (Cohen et al. 1983; Phillips et al. 1986). In a study by Phillips et al. (1986), the most severe symptoms occurred 20 days into withdrawal on the final day of methadone dosage. Other studies have found that withdrawal symptoms are a primary cause of relapse among drug-free individuals (Wikler 1980) and that anticipation of withdrawal symptoms is a deterrent to seeking treatment for active drug users (Bradley et al. 1987).

Research as early as 1973 called for “a greater appreciation of sociocultural and psychological factors” influencing addiction (Glaser 1974:231), when studies published in the New England Journal of Medicine (Cushman 1973; Weisman et al. 1973) reported that the average daily dose of heroin used on the street was insufficient to produce dependence (Glaser 1974:231; Stimmel and Kreek 1983). When symptoms could not be fully explained by physical factors, addiction was reclassified as “pseudoheroinism” (Glaser 1974; Primm and Bath 1973). Symptom falsification was introduced as an alternative with the idea that the pain and discomfort of withdrawal were distortions of the addict’s psyche. This led many drug treatment providers to stabilize methadone doses at levels lower than those effective for rehabilitation (Cooper 1992; Cooper et al. 1983). Despite the recognition of a psychological component of withdrawal, there is a need for more research that addresses withdrawal within a psychosocial framework in which subjective experiences and the influence of social context are viewed as factors that influence constructs of pain and pain avoidance.

**Interviews with Intravenous Drug Users**

Three types of data were used in this study: confidential questionnaires, interviews, and “street ethnography.” A questionnaire was administered to 116 people during the spring of 1989 at a Massachusetts residential drug treatment program and at a 21-day detoxification program. All clients in each facility were asked to participate and were informed that participation was both voluntary and confidential. Questionnaire and interview participants came from a variety of cities and towns throughout Massachusetts and from a range of working-class and middle-class families.

The questionnaire included 30 multiple-choice and open-ended questions designed to elicit ethnographic information, types of withdrawal symptoms experienced, the social context of withdrawal, and the changes in self-conception and behavior when experiencing withdrawal. Fifteen percent of the people who completed the questionnaire were interviewed during the following month. The interviews probed deeper into the stages of the pain condition with respect to the interviewees’ sense of self and of the world around them.
Of the 116 people who completed the questionnaire, 70 percent were male and 30 percent were female. Eighty-five percent were white, 6 percent were black, 6 percent were Hispanic, and 3 percent were Cape Verdian. Eighty-five percent used drugs intravenously, and the remainder smoked cocaine and used a variety of prescription pills (see Table 1). Of those in the sample who used drugs intravenously, 40 percent regularly injected both heroin and cocaine, 33 percent used heroin only, and 10 percent used cocaine only. Ninety-two percent of all study participants said that they experienced withdrawal symptoms; 75 percent suffered from withdrawal within three months following their first injection (see Table 2).

Research was simultaneously conducted on the streets (outside the drug treatment facilities) of a central Massachusetts city of 185,000 with an estimated population of 4,000 to 5,000 injection drug users. The 15-block neighborhood was an interracial, physically degraded area of working-class and unemployed residents, once home to middle-class families and still home to the campus of a prestigious university. The city itself suffers from a state of steady economic decline, having lost many jobs to factory closings and the recent closing of a military training base. No other factory or service industry jobs have replaced those lost.

### TABLE 1

Profile of study participants by age, sex, ethnicity, and drug use (N = 116).

<table>
<thead>
<tr>
<th>Drug use</th>
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<tbody>
<tr>
<td>Injecting drug users</td>
<td>85%</td>
</tr>
<tr>
<td>Noninjecting drug users</td>
<td>15%</td>
</tr>
</tbody>
</table>

| Number of years using drugs | 2–25 years |
| Daily intake of heroin<sup>a</sup> | |
| <7 bags | 59% |
| 8 to 15 bags | 30% |
| ≥16 bags | 11% |

| Daily intake of cocaine | |
| <1 gram | 19% |
| 1 to 5 grams | 61% |
| ≥6 grams | 20% |

| Sex | |
| Male | 60% |
| Female | 40% |

| Mean age (range) | 31 years (20–47) |

| Ethnicity | |
| White | 85% |
| African American | 6% |
| Hispanic | 6% |
| Cape Verdian | 3% |

<sup>a</sup>Forty percent of sample injected a combination of heroin and cocaine.
TABLE 2
Prevalence of withdrawal symptoms in injectors of heroin and heroin and cocaine (N = 85).

<table>
<thead>
<tr>
<th>Experience drug withdrawal symptoms</th>
<th>94%</th>
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<tbody>
<tr>
<td>Develop symptoms within three months of initiation to the use of heroin, cocaine, or a combination thereof</td>
<td>75%</td>
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<tr>
<td>Report withdrawal symptoms 3–7 times/week</td>
<td>66%</td>
</tr>
<tr>
<td>Experience symptoms 1–3 hours/day</td>
<td>64%</td>
</tr>
<tr>
<td>Experience symptoms 4–8 hours/day</td>
<td>20%</td>
</tr>
<tr>
<td>Experience symptoms 9 or more hours/day</td>
<td>16%</td>
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My research was conducted as a part of ongoing public health intervention work, which involved going out into the neighborhood as part of an AIDS outreach team of recovering drug users and health professionals equipped with prevention materials. We visited areas frequented by drug users on the street, in soup kitchens, and in places where they injected drugs as well as talking with them at home, in jail, and occasionally in the hospital. Street contacts (N = 117) included those who were known by name or with whom at least two conversations were held. Of these contacts, 40 percent were white, 37 percent were Hispanic, and 23 percent were black.

Drug Users and Their Pain: Expanding the Clinical Boundaries of Chronic Pain

Many people assume that injection drug users feel little or no pain, much less chronic pain, while using drugs. The analgesic effect of substances such as heroin, cocaine, and methadone is thought to shield drug users from pain altogether. The participants in this study, however, report a degree and continuity of pain that indicates what is essentially a chronic pain condition. This section proposes a reconceptualization of withdrawal symptoms by viewing them as part of a chronic pain condition.

Chronic pain is recognized with reservation by the medical establishment and is diagnosed only when no organic origin can be found to explain the presence of persistent pain. Research on narcotic withdrawal focuses on the physiological effects of the drugs and the patterns and degree of symptoms they produce. Neither the addiction literature nor the chronic pain literature recognizes the physical pain associated with drug addiction as a chronic pain condition. The pain of drug users does not fall within the clinical definition of chronic pain because it is believed that if a drug user merely stops using drugs, the pain condition will dissolve. In other words, drug users’ pain is not considered chronic because it is thought that they have control over ending it. There are two problems with this position. First, a drug user is physically addicted to a substance that is contributing to the recurrence of pain, so that for most users successful cessation of drug use is not an option without the assistance of treatment. Second, even if the drug user stops injecting, the pain persists. This research demonstrates that injection drug users experience chronic...
pain on two levels: the physical and the emotional. The common dimensions of these two levels need to be explored because physical and emotional pain are often experienced simultaneously by these pain sufferers.

While the persistence of physical pain is recognized by clinical science to be an aspect of withdrawal, less is known about the emotional realm of withdrawal and its role in sustaining addiction. Low self-esteem has been postulated as one consequence of persistent painful experiences. Researchers in the substance abuse field cite low self-esteem and its social consequences as correlates and predictors of drug abuse (Catton and Shain 1976; Chien et al. 1964; Pandina and Schuele 1983; Svobodny 1982) and as a necessary focus in treating drug addiction successfully (Biase and Sullivan 1984). Feelings of rejection, shame, isolation, and inadequacy act as injuries to a person’s spirit, individual identity, and social identity. This distress response is believed to develop gradually as a person absorbs painful experiences derived from neglect, poverty, and abuse into a concept of self.

Some research has recognized that the negative experience of the everyday self is what differentiates the addict from the nonaddict even before the onset of addiction (Khantzian et al. 1974; Sullivan and Guglielmo 1985). One street addict lucidly communicated this in describing how living with alcoholic parents affected him:

I guess it starts at an early age when you have to live another life. You can’t be yourself because you’ve got so much pain. So you put your true self away, you don’t want to see that person. I kept that turmoil in the closet. I didn’t let the neighbors know what was going on. I had to put on a happy face outside, and inside I was dying. You’re the victim, but you think you are the guilty one.

Hilbert, in his writings on how chronic pain patients must reconstruct themselves in the world in order to live with their pain, claims that “when pain is chronic, one might expect the appropriate method of managing it to become chronic also” (1984:370). Sufferers attempting to normalize their pain often vacillate between disclosure and concealment. In many situations, it is either inappropriate or impossible for chronic pain sufferers to reveal the pain they experience. Two men explain, through their experiences growing up, how pain accumulated:

Keith: The ghetto to me was like living in a maze. There was no way out. What I did was to just keep filtering in and out, in and out of the maze trying to find a way out. By the time I understood that there was an open door, that I could actually get out, I was comfortable enough that I didn’t even want to. I felt like I had wasted so much time and done so much bad, that I wouldn’t even be accepted into the new world. Just at that time, a program that trains you for a good job came into my life and made me feel that maybe I could change the way my life was going. I got a job at the Department of Employment Security. I felt like I was on top of the world. But really, I was uncomfortable. I was in a place that I thought I shouldn’t be. It was a whole new world. I’d sit in the lunchroom and I’d hear people talking about advancement and I didn’t think that I had the qualifications to bring myself up. My actions were so totally different from other people’s. I had like a “ghetto mentality” even though I could act “as if” very, very well. They taught me that in technical language from the start. But I wasn’t feeling what I was doing. I wasn’t feeling good about where I was. I didn’t know anything about accomplishments. If I had known all of that I think I could have made it, but I didn’t know the steps.
I was told in my neighborhood that I was a “token nigger” ’cause I worked downtown. That hurt me so I had to get high on the job to feel comfortable. There weren’t many blacks working in my office and the guys in the neighborhood helped me doubt myself. It worked well because that was my whole life anyway, downing myself. I got promoted, I had my own office, my own desk, name plate and telephone, and that scared the hell out of me and I resigned. . . . It’s much easier in the world that we live in to use drugs. It is accepted more than crying about something that hurts. What is accessible is drugs and that’s what we use in replacement.

Tevin: All of us kids were very athletic, always playing sports. But do you know how it feels not to have anybody watching, not to have your father helping out? Everybody else’s father was there. My father, never there. He couldn’t be bothered. Us kids we could see these things. That something wasn’t right. Anger was my life. It consumed me. I got into fights a lot to release it. All these experiences and feelings contributed to me, to my addiction. All of this stuff. I was always looking for a way out.

When I started telling people about my fears and anger about things I have never said anything about, I realized how much energy it takes to be angry. Anger is an addiction in itself. It kept me from feeling, from getting close to people. The same thing that drugs did. I didn’t have to feel angry, I could get away through drugs. I had a fear of letting people know who I was. I didn’t know myself who I was. There were too many things I just couldn’t show of myself. On the street you couldn’t be vulnerable. I couldn’t open up no door to people because out there they would use them against you in a heartbeat. What I learned growing up is that nobody was going to be there for me, I was on my own.

These two descriptions of what drug users themselves think contributed to their drug use demonstrate the diversity in sources of pain—poverty, racial discrimination, and family neglect and abuse. They also illustrate how pain sufferers view themselves as divorced from the everyday world. Their world of pain is a different world from that of those who are without pain.

The social and psychological isolation of the chronic pain sufferer is in part a consequence of the lack of a shared understanding of chronic pain between the clinician and the sufferer. The notion that the pain an injection drug user feels when using drugs is self-inflicted and thus not a legitimate chronic condition contradicts drug users’ explanations of their pain condition. The schism results from different definitions and cultural expressions of pain in each context. Further distance between sufferers’ and clinicians’ understandings of pain stems from the sufferer’s limited power and vocabulary to fully comprehend the dimensions of the pain and to communicate these effectively. Withdrawal pain and its management become an everyday obstacle to recovery for the addict and a serious obstacle to HIV prevention.

The Personal Experience of Withdrawal

Drug addicts talk about pain a lot. Most often they refer to it in connection with withdrawal: being sick, being dope sick, or crashing on cocaine. They talk about symptoms: the aches, the muscle and stomach cramps, the shakes, the runny eyes and nose. The physical symptoms of withdrawal were referred to by all participants and are virtually identical to those identified through clinical research.
“Sick” and “crashing” are the terms used to refer to the symptoms associated with drug withdrawal. The more common meaning of sick (not feeling well because of any type of ailment) seldom enters the drug user’s vocabulary both because dope sickness is an everyday occurrence and because it is often difficult to distinguish it from other kinds of illnesses. “Sick sick” is the drug user’s equivalent of the common meaning of the word sick. As one user explains:

With dope sickness, your whole body aches and your stomach is all upset, you’re drained out and get the chills. If you got a cold or something, you can deal with it. That’s “sick sick.” Dope sickness is like a combination of everything all put together.

Other medical terms also help to structure the language of this illness category. For example, to inject oneself or to be injected with heroin or cocaine is “to get cured.” People whose role is to inject others for a fee are sometimes referred to as “doctors.” Injections drug users do not, however, refer to themselves as patients, because they are not particularly comfortable with the sick role. For them, the sole effort of each day is to “get cured” as quickly and efficiently as possible, as described by John in the following passage:

When you wake up in the morning, you know that it’s not going to get any better. And before it hits the next stage you push yourself, you force yourself to get the hell out of the house, go hustle and get well; as much as it is the last thing you want to do. You just lay there, you have no incentive to take a shower and you know you’d better look halfway decent depending on what your hustle is, to go out in public and hustle money up. And it stinks, it’s terrible. But you’d better do it quick before you get to a stage where you become so pathetic that you can’t hustle even if you want to.

Of those who injected heroin or both heroin and cocaine, 66 percent reported frequently experiencing symptoms of withdrawal (3 days/week). Of those users, 64 percent were sick 1 to 3 hours each day; 20 percent were sick 4 to 8 hours each day; and 16 percent were sick 9 or more hours each day (see Table 2). Three-quarters of the sample said that they inject drugs to avoid or relieve withdrawal symptoms, and one-third described their symptoms as “almost unbearable.” Amounts of cocaine and heroin used did not seem to make a difference in symptom intensity. Low levels of drug use did not ensure minor experience with withdrawal symptoms nor did high levels of drug use guarantee more pronounced symptoms. Users who said that they injected drugs to extinguish withdrawal symptoms reported suffering extreme pain from withdrawal more often than other users (see Table 3; the difference was statistically significant). Further discussions with injection drug users helped to make sense of this association.

The Mythological Transformation during Withdrawal

Initial responses to questions in the survey and during the interviews described physical and psychological symptoms of withdrawal, such as muscle cramps, depression, and anxiety. As each of the interviews progressed, however, respondents spontaneously alluded to emotional traumas, desperate visions, and dramatic allegories. What was communicated was that in coming down from the high of the drug and into the physical aches and pains of withdrawal, they simultaneously came
down into a world where all this other pain existed. For drug users, withdrawal pain is allegorical—the physical manifestation of accumulated emotional pain. On the surface, drug users and clinicians appear to speak the same language of pain, but a phenomenological mode of inquiry reveals a much more meaning-laden explanation of withdrawal that blurs distinctions between the physical and emotional realms. I explore these stories of pain by using myth as a conceptual model.

According to Roland Barthes, “myth is always a double system—meaning is always there to present the form; the form is always there to outdistance meaning” (1957:123). Barthes’s depiction of the function of myth is lucidly described through his example of looking out the window of a moving car. One can see, at one moment, the scenery through the window and, in the very next moment, the presence of the glass. When one comes into focus, the other is obscured. Barthes stresses that “myth hides nothing—its function is to distort, rather than to make disappear” (1957:121). “It is neither a lie nor a confession: it is an inflexion” (1957:129).

I have chosen to examine withdrawal by using myth as a conceptual model for two reasons. First, the concept of myth explores the problem of meaning, which cannot be unraveled through the use of psychological or physiological models (Hilbert 1984; Kleinman and Good 1985; Kotarba 1983). Second, the myth concept allows for a cultural interpretation of withdrawal and a departure from the typical psychological models that focus predominantly on individual beliefs and actions.

Withdrawal can be analyzed as myth because one effect of withdrawal is that it distorts one’s experience of pain. This distortion occurs in two ways. First, it functions as a means of escape from emotional pain. The physical pain (the form) masks the emotional pain (the meaning); “myth transforms meaning into form,” Barthes says (1957:131). This kind of escape from emotional pain through physical pain is communicated by someone who has been using drugs for 24 years:

'It all goes back to when you were a kid. Every drug addict can tell you, that’s where it started. Eventually, the drinking and smoking pot lead to hard drugs because there’s never enough to keep the pain away. Finally the drug controls you, and you don’t feel that pain anymore. The pain you feel comes from the drug,'
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getting the drug, being sick from the drug. That’s your pain, and it is the only thing you worry about.

In this case, any pain that is felt can be attributed to the effects of the drug that is injected.

Second, withdrawal serves as a forum to express and present emotional pain in a culturally salient form—through the physical body. As the signification of myth, the physical body makes us understand something and it imposes it on us, “so that myth is read as a factual system whereas it is but a semiological system” (Barthes 1957:131). Withdrawal is read as the physical manifestation of drug addiction when it is actually much more. It provides a form for the presentation of emotional pain by blurring the physical and emotional into one sensation, manifest as being sick. Addicts are not successful at escaping their pain throughout daily life, as the daily onset of withdrawal is an experience of beginning to relive the pain. One drug user says that she can feel her emotions as physical pain:

The mental pain caused me my addiction to begin with. Mental pain you can feel. It can get so bad you can feel it physically. I refer to it as hell, and I’m not going back to hell anymore, no thank you. I’m not going to die in hell, that’s for sure.

In the three following descriptions, the physical pain of withdrawal is explained by using familiar paradigms for describing emotional pain. When asked whether being sick reminded her of anything she had experienced before becoming addicted, Andrea addressed the emotional aspect of withdrawal:

Yeah, I feel obsessed to the point like if someone was gonna do something to hurt my family. You know that protective ness? That’s like the same protection you have when you need that hit. You’d do anything to get it like you’d do anything to keep someone from hurting your family. You’d do anything to stop feeling this way. How it feels is the same as how it feels when you know someone is cheating on you, you hurt, and that’s how it feels to be sick. I feel very impulsive and very defensive.

Paul uses an emotional metaphor to stress the power of addiction and pain: “Addiction is like a big brother. He’s telling you all the time, ‘I can take the pain away; just pay me what I’ll need.’ ” The metaphor of big brother that Paul uses to describe addiction casts it as an emotional need; big brothers take care of you, they know more, they protect and guide you.

Don responds similarly to the same question: “You feel lonely. You feel like your best friend left you. That’s what it feels like. You really need the drug like you really need to talk to somebody—someone that’s been a major part of your life.”

The most poignant images of how withdrawal functions to distort form and meaning surfaced in response to the question: “how would you explain what sickness is like to someone who had never been a drug user?”

I feel like a baby thrown out in the cold, freezing to death and unable to get warm or move. And no one will help you.

Being a patient that needs medicine and will die without it. Sometimes it feels like those people in Blade Runner [a 1982 film] that are trying to find a way to make their bodies live longer, but they can’t because they were made to die in a short time. There’s a power to that.
The kind of desperation I feel would be like seeing someone you love going to jump off a bridge, and you need to grab them before they fall.

Like everyone you knew was in a plane crash, and you were left alone with absolutely nothing.

These dramatic descriptions of a pain condition that is most commonly diagnosed as physical in nature suggests that the worst symptoms of withdrawal do not get more physically painful, they get more emotionally painful. These descriptions do not parallel the degree of physical discomfort reported either by clinical researchers or by the respondents themselves. The dimension of pain that withdrawal encompasses makes it considerably more complex than the current literature suggests.

**Pain and Power**

Although it is not certain that all injection drug users use drugs in response to emotional pain and are aware of and can articulate the depth of the experience when they do, the participants in this study described, often coincidentally, the two kinds of pain they felt. Sullivan and Guglielmo (1985) have conducted one of the few studies that address emotional pain as an aspect of addiction. Their research concludes that the emotional pain of the drug abuser is a response to stressors and is a major factor in a drug user’s motivation to use drugs. They also claim that this pain is “imperceptible” to the user. My study, on the other hand, indicates that drug users can articulate painful experiences but do not know how to resolve them. They seem, rather, to legitimize their emotional pain through a “real pain” experience.

Drug use provides an initiate with a framework for actualizing the purpose and the meaning of pain. Pain, once an all-consuming-yet-obscure entity without a source and without end (Kleinman 1988), can then be exposed and expressed in a way that was not possible before drug use. Drug use allows private feelings a medium of public expression and meaning.

When a drug user goes through withdrawal, the body is the mediator of pain. When a drug user’s pain is felt through the physical body, it can be both shared through language and extinguished. One consequence of withdrawal is that drug users believe that they are in control of their pleasure and their pain. This unrivaled sense of power keeps them in the cycle of drug addiction and at continued risk for HIV infection. A consideration of the interrelation between pain and power is essential in understanding withdrawal as a barrier to HIV prevention. The paradigms of the individual body and the social body help to illustrate this connection. The individual body refers to one’s experience as an individual and the social body to people’s experience of themselves as part of the social world (Schepet Hughes and Lock 1987). The “individual body” uses myth, the “social body” supports myth, and this affects HIV transmission.

**The Individual Body of Pain**

A major problem for drug-injecting chronic pain sufferers is that their pain experience puts them at risk for HIV transmission. Two related elements of the pain experience make HIV prevention a tremendous challenge for the drug user. The first is that the impulse to get rid of pain is stronger than the will to bear it. The
second is that the nature of the pain creates a void, it erases the world, often including the reality of AIDS. Their particular construction of the pain experience makes them unique among chronic pain sufferers and those at high risk for HIV infection. The following excerpt illustrates both these points.

When I was first withdrawing, the depression was so crushing I felt suicidal. Each time it’s worse, it really is. As you go on, the mental takes over from the physical. When you start to crash you feel extreme pessimism. Over time the world becomes smaller and smaller. Nothing matters. I don’t care if you told me my right arm was gonna fall off if I robbed you. It would be like, so what, it’s only my arm. I’ll steal another one later.

In her extensive account of the meaning of pain in torture, Elaine Scarry found that “the problem of pain is bound up with the problem of power” (1985:12). Intense pain is world destroying (p. 29), according to Scarry, and the sufferer’s response is to objectify, to create physical or symbolic distance between oneself and one’s pain. As it is for other chronic pain sufferers, the theme of power and pain is paramount in drug users’ daily lives. Essentially, drug users feel powerful when they are high and powerless when they are sick. One drug user recounts his early days of getting high and how it brought a sense of control to his life:

It was a pleasure when I started getting high. Drugs were a pleasure, the feeling was beautiful at the beginning, it was relaxing, comfortable, it was warm. That’s what I fell in love with, the warmth. Thereafter, I realized I could dismiss all those feelings I had. Then when my daughter was born, if I wanted to dismiss that, all I had to do was “nod out.” Now I could be like my brothers and my father, in my own way, and not deal with my child. I’d come home, lay in the bed and let her do all the work. My father did the same thing.

Using drugs is a means of controlling pain—unresolved and torturous feelings and life circumstances.10 Pain is somatized through withdrawal in an attempt to bring it under control. Drug users commonly refer to pain with such words as “the curse,” “hell,” “it blocked the whole world out,” “it gets worse each time.” All these descriptors move toward the all-encompassing. Anthropological accounts of chronic pain also present pain as something that is larger than the individual (Garro 1992; Scarry 1985). One of Garro’s informants (a female university faculty member) describes her temporomandibular joint disorder in this way: “It’s like a shadow that throws the other parts of my life into brighter contrast. You see my brights are brighter, ’cause I have this darkness hovering all around the edges” (1992:129). Weapon or demon metaphors are often used to describe pain (see also Good 1992). Scarry’s respondents refer to pain as a “knife, or bones that cut through.”

People who live with chronic pain all describe a disempowerment, but the source of pain is different for drug users. In their metaphors, pain appears to consume them from within. Pain is fear, loneliness, “the void that needs filling,” a vast emptiness that makes “the world seem like it’s at a standstill.” Statements from three study participants portray the intensity of this experience:

When you first wake up, you’re aware of your surroundings and that you feel sick. What happens after that is you lose touch with your surroundings, and the only
thing your mind goes to is getting the fix. All you want to do is fill that void around you.

I felt so sick. I felt totally insane, like a different person. I was really confused about where my place was in society; that I didn’t even deserve to hold a job. Sometimes I felt like I didn’t even deserve to eat ‘cause I didn’t feel worth anything.

Time goes by slower [when you are sick] because it seems like you are never going to fill that feeling, and until the void gets filled the world seems like it’s at a standstill. Nothing else important is happening. But in reality, time is going by really super fast.

Drug users refer to withdrawal pain as though it were an integral part of them. This conception of the pain begins to explain the desperation addicts feel during withdrawal and their often compulsive acts to remedy it.

*The Social Body of Pain*

Good has theorized from his cross-cultural work with illness experiences that “as new medical terms become known in a society, they find their way into existing semantic networks” (Good 1977:54). A number of anthropologists have used this concept in analyzing illness explanations in culturally pluralistic societies in New Guinea, Thailand, and Haiti (Farmer 1990; Lindenbaum 1985; Muecke 1979; Nichter 1981). The process by which new illness concepts are grouped into existing conceptual categories rather than remaining separate is apparent in how drug users incorporate information about HIV into their daily routines.

Injection drug users in this study appear to be interpreting and responding to AIDS within the same framework they use to deal with other illnesses that result from drug injection (e.g., endocarditis, hepatitis, shingles). They report that before the advent of the HIV epidemic, they employed no effective way of reducing their risk of contracting these infections; needle sharing and cleaning syringes with dirty water were commonly accepted practices. For most drug users, health risks are incorporated into a schema of risk events that include all other risks (Connors 1992). This semantic network is a hierarchy in which risks are ranked. Activities viewed as the most risky do not generally include contagious disease but entail the danger of arrest (carrying a needle) or being “set up” (dealing drugs to “an undercover”). Risks are most often ranked based on one single objective: getting high to avoid or relieve the symptoms of withdrawal. Within this construction of risk, the risk of HIV transmission was not given first priority by most injection drug users in this study.

Even though avoiding AIDS is often not a first priority, drug users do fear infection and are tested for HIV surprisingly often. On the other hand, they are often powerless in the face of pain to avoid AIDS-related risk situations. Some users explain this dilemma:

There isn’t much talk about AIDS. I was shooting with people who were positive, that’s how crazy I was. . . . It’s kind of like driving a car really fast. You just say, “I’m gonna go really fast, I just hope I don’t get in an accident.” Some people hit a pole, some people make it.
It's psychological. You get the dope in your hands and half the pains go away. People say AIDS is a matter of life and death, but when you’re in that condition, when you’re sick, you don’t give a shit about life or death. You’re killing yourself anyways.

The success of public health AIDS prevention efforts has been dependent on the social cohesiveness of drug users for communication about and prevention of HIV infection. The expectation has been that the drug-using community would take charge of HIV prevention in ways similar to the collective efforts of the gay community, but behavioral change has not been met with the same degree of social support in the drug community as it has within the gay community. First impressions lead one to think that the drug-using subculture operates in a way that would not invite social support because of competition for resources and the desperation of those competing. In fact, social support does exist, but it operates predominantly within the context of the pain experience.

One of the main effects of the subculture is to support the mythology of withdrawal: pain is controlled by using drugs. As one’s experience as a person in pain helps to create the myth of withdrawal, one’s experience as a part of the subculture supports it. Although drug users take drugs in an attempt to mask pain, the continual resurfacing of pain through withdrawal causes it to become a unifying symbol. A new user (one year) says:

I had been a jock in high school, had lost my brother [he started using dope], and broke up with my girlfriend. I was afraid to go to college. All the positives weren’t working out. Went out with my cousin one night and we turned me onto dope and the needle. He brought me into it, took me to these places but kept saying: “don’t ever do this, don’t ever get into this, it’s evil.” Then I really wanted to do it. It was mysterious. I was feeling depressed, like I had nobody, I needed an identity real bad. It really fulfilled the emptiness I had. When I met these junkies, I knew that they felt the same way I did. We’d “run” together. I felt good again.

The immediacy of pain for all drug users creates solidarity. This point of connection develops into a familiar pattern of relating. Part of the reason for lending a needle is that the lender knows what it is like to be in pain (“only another addict can know how I feel”). Because there is a shared objective to extinguish pain, “just saying no” is not easy for another dope sick drug user:

Occasionally you hear people say: “Yeah, you can use em [my needle], but you don’t have AIDS do ya”? If they do, it’s gonna be “no, I don’t.” They just need to use them so bad. They [the lenders] don’t care ’cause they’re shooting so much dope anyway.

An elaborate system of social support makes the daily and sometimes hourly relief of pain possible. Support is rendered in the form of needle sharing, drug sharing, the running partner relationship (a two-person team that scams, buys, and shoots drugs together), money lending, and running shooting galleries in exchange for drugs. This support system has been indirectly referred to within the diverse body of literature on AIDS and drug use as “needle sharing for the purpose of reciprocity and obligation” (Bowser et al., n.d.; Des Jarlais et al. 1986; Feldman and Biernacki, n.d.).
It is the collective recognition of pain in the subculture that adds confirmation to sufferers’ experience of their pain as normal. It diminishes feelings of alienation and affirms continued drug use. Social support is thus operating within the subculture, but it works against HIV prevention. Where needle sharing patterns are changing, they are doing so within the context of the subcultural norms on sharing. Users are limiting their needle sharing to an often irrational choice of “safe partners,” diversifying their sharing styles to carry both a personal and a lending set of works, or participating in one-way exchanges (where the needle is used and then given away) (Connors 1990, 1992; The National Institute on Drug Abuse 1992). In other words, most drug injectors continue to share HIV-infected needles and other drug paraphernalia.

Conclusion

In my attempt to explain the pain experience of injection drug users in this study, I have placed withdrawal into the preexisting category of chronic pain. The pain experience of withdrawal does not share all of the experiential qualities of the pain experiences of other chronic pain sufferers. The chronic pain I describe here differs with respect to the source of the pain and the way it is expressed. Further research into suffering configured as pain may give way to new frameworks by which to deconstruct and interpret this phenomenon.

On the basis of this study, I propose that drug withdrawal be considered a chronic pain condition to recognize that it bridges the physical and the emotional realms especially regarding feelings of rejection, shame, inadequacy, and isolation. This research suggests that the physical effects of opiates and amphetamines not be viewed as the only contributing factor to the pain that drug users experience. Rather, the physical effects of drug injection need to be explored as a symptom of a more extensive chronic condition in which pain is both the reason for and the consequence of drug addiction.

In addition to the fact that the meaning of withdrawal affects the quality of symptoms and the intensity of pain, meaning affects how pain is expressed. What makes avoiding needle sharing and using bleach to clean needles difficult for many is that tolerance of withdrawal symptoms requires tolerating not just physical symptoms but a more complex constellation of symptoms. Drug withdrawal demonstrates an illness condition where symptoms explain and reaffirm personal and social experience (Stalano 1987).

Outreach education may need to address the notion of dope and coke sickness in teaching about AIDS transmission and AIDS prevention. If researchers, health educators, and outreach workers can come to a better understanding of the role of withdrawal in noncompliance with AIDS risk reduction, this may improve the effectiveness of the prevention message. In fighting the AIDS epidemic, the more we understand about “the subtle coercions which limit the possibilities of choice” (Weeks 1986:17), the better we will be at defining the criteria by which this subculture decides between low-risk and high-risk behaviors.
NOTES

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1. Withdrawal is defined as the period after injection of a narcotic substance when an individual is no longer experiencing the effect (or at least the initial effect) of the drug. This period can begin as soon as 20 minutes after injection for cocaine users and a few hours for heroin and other substance users. This definition includes the more extensive period of withdrawal when an individual ceases drug use altogether. The drug user most often refers to withdrawal as being “dope sick,” “sick,” or “crashing.” “Sick” is a term that refers to symptoms of withdrawal in general; “dope sick” commonly refers to the symptoms of heroin injection; “crashing” commonly refers to the symptoms of cocaine withdrawal. Forty percent of the injection drug users in this study injected a combination of cocaine and heroin or alternated use of both (as well as other substances such as dilaudid) during a 24-hour period.

2. “Real” and “unreal” pain are terms borrowed from Jackson (1992:138) that refer to the labels (spoken and unspoken) clinicians and patients used to talk about pain in her study at a pain treatment center.

3. Moore and Dworkin (1988) demonstrate that ethnicity plays a stronger role in pain perception than professional socialization. The pain perceptions of Chinese patients and doctors were more similar than were those of American Caucasians and Scandinavians. In the study, pain was differentiated as physical or emotional and described as “real” and “imagined” by American Caucasians. No such distinction was made among Chinese subjects, rather “a multidimensional concept” was offered (p. 201). Bates, Edwards, and Anderson (1993) and Bates and Edwards (1992) have also found that there is ethnic variation in the experience of chronic pain.

4. The interview format was based on a phenomenological model provided by Byron Good (March 1986).

5. A possible limitation of the questionnaire portion of the study is that it included 15 percent noninjection drug users. While there were no differences between how injection drug users and other drug users in this sample experienced withdrawal, their risks of transmitting HIV are different. Injection drug users use and share needles, whereas other drug users do not. In the analysis of how withdrawal influences risks related to HIV transmission, this article focused on injection drug users’ behavior and subculture rather than generalizing about drug users as a whole. The details of HIV risk-taking among non-needle-using drug users are not explored because the author conducted all follow-up interviews with injection drug users in order to focus the study on one group of drug users.

6. Similar results were found in studies on methadone and withdrawal symptoms (Gossop et al. 1987; Phillips et al. 1986).

7. Schepers-Hughes and Lock discuss the assumption of an “other” or a “double” in illness, which is expressed through cultural images and metaphors (1986:137). Here, the double represents the layers of stigma, rejection, fear, and exclusion attached to particularly dreaded diseases (p. 137). For example, cancer has long been seen as a sign of internal repression (Sontag 1988), and the recent condition of hypoglycemia is said to be linked to issues of personal control by its sufferers (Hunt et al. 1990). The double meaning they refer to seems to be more like Good’s “core cultural symbols” (1977) than the double imaging or distortion that emerges from mythologizing withdrawal symptoms. Withdrawal symptoms
are allegorical, not metaphorical, precisely because communication through the medium of language is limited by the social suppression of emotional expression.

8. In using Barthes’s definition of myth, I understand myth to be a system of communication through the modes of speech, writing, or representation as well as a system of signs. Myth is a metalanguage, says Barthes, “because it is a second language in which one speaks about the first” (p. 112). The signifier in myth can be looked at from two points of view: as a final term of the linguistic system or as the first term of the mythical system. In other words, there is a plane of language in which the signifier is meaning and the plane of myth in which the signifier is form. From these develops a third term of myth-signification. As Barthes puts it: “the form does not suppress the meaning, it only impoverishes it, it puts it at a distance, it holds it at one’s disposal” (1957:118). Barthes’ theory of myth developed from his reading of Ferdinand Saussure, who speaks of collective representations as sign systems.

This myth model is similar but not identical to Obeyesekere’s myth model. Obeyesekere proposes that even in cases of psychosis, the myth “is expressed in a publically constituted idiom [in his example, religious] that renders intelligible the action of the patient because the patient has conceptualized his inner experience in terms of symbols” (1981:103). In the use of myth by injection drug users, the pain condition is distorted through myth rather than clarified for the outsider.

9. Kleinman and Good have written extensively about somatization in both nonwestern and middle-class American contexts (Good 1992; Kleinman 1980; Kleinman and Good 1985). They define somatization as “the expression of personal and social distress in an idiom of bodily complaints and medical help seeking” (Kleinman and Good 1985:430). Kleinman cites chronic somatization as having numerous sources: a result of physical problems accompanying a chronic psychiatric disorder, such as hysteria or schizophrenia or a chronic medical disorder that is exacerbated by “psychosocial stress in local contexts of power” (e.g., employer abuse of power).

10. In a study conducted to discern the subjective perception of the high among heroin and cocaine users, Seecof and Tenant (1986) found that power was the second most frequent response given for drug use among males and that power, strength, and control all ranked among the top ten most frequent responses across gender.

11. Kleinman poses that the way to discern the meanings that are shared by the popular culture from those that are restricted to particular subgroups “is to speak of local systems of knowledge and relationships that inform how we regard symptoms [of illness]” (1988:15).

12. In a recent ethnographic study sponsored by NIDA, it was found that over 60 percent of study participants (active street injection drug users) had been tested for HIV at least twice (The National Institute on Drug Abuse 1992).

13. Kotarba found this same phenomenon of normalizing pain to occur among construction workers who experience a high degree of physical injury; he refers to it as a “chronic pain subculture” (1983:136).

14. The medical literature has begun to link the presence of physical pain with the experience of painful situations. Goodman and McGrath, in their review of the epidemiology of pain in children and adolescents, suggest that “physical pain itself is only a part of the cause of the handicap accompanying pain” (1991:247) and pose that a nonlinear relationship exists between the physical disorder, its symptoms, and pain’s restriction of activities and a person’s social role.

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